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UNIVERSITY OF ALBERTA

Countertransference: A Human Response to Caring

BY ©

Irene Christina Ens

A thesis submitted to the Faculty of Graduate
Studies and Research in partial fulfillment
of the requirements for the degree of
Master of Nursing

DEPARTMENT OF NURSING

Edmonton, Alberta
Fall 1993

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Abstract

The purpose of this study was to evolve a structural description of nurses' experience of countertransference. The phenomenological method was chosen for the study. The sample consisted of five participants who met selection criteria. The participants gave audiotaped descriptions of their experiences in caring for patients for whom they experienced countertransference. The lived experience of countertransference emerged from the findings of this study as a process of the continuous growth of self-awareness. Initially, the experience entailed the struggle to abandon objectivity, emotional neutrality, and therapeutic omnipotence. It was the abandonment of these principles which enabled the nurse to begin to use the self's experienced emotions therapeutically in interactions with patients. For the participants, the feelings aroused in the self came to be understood as having meaning within the concept of countertransference and thus, came to be understood as a normal, human response to caring. It is the continuing ability of these nurses to transcend this normal, human response, and to use their growing self-awareness to provide an appropriate level of care to the patient, that is the hallmark of the lived experience.

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Chapter 1

Introduction

In 1900, Knight wrote "nurses should be able to enter into psychic relations with their patients; otherwise the value of their services is much lessened and they may be harmful" (p. 111). This statement is no less true today than it was in 1900. The ways and means of carrying out 'psychic' relations with patients is an ongoing area of investigation as nurses seek to define the variables which enable them to provide care based on an interpersonal relationship. This is particularly true in psychiatric/mental health nursing where nurses must enter into relationships with patients which are corrective rather than harmful. The negotiation of a successful nurse-patient interaction in the psychiatric/mental health practice area depends on a number of variables, which include the human response to caring and therapeutic use of self. Both of these variables are influenced by the presence of countertransference, a feeling state in the nurse which may be a normal human response to caring. Conversely, the ability of the nurse to make therapeutic use of the self may be blocked by the presence of countertransference. In either case, the psychodynamic concept of countertransference provides a framework from which to understand the processes which are occurring within the nurse during the course of an interaction with a patient. Therefore, an exploration of countertransference phenomena may provide insights about what the parameters of the nurse-patient relationship should be. These parameters are particularly difficult to define in the psychiatric/mental health practice area because many patients come to the area with severe personality disturbances. It is necessary that the nurse be clear as to what the patient brings to the interaction and what the nurse brings.

An understanding of what the nurse brings to the nurse-patient interaction is contained within the domain of nursing therapeutics (Meleis, 1991). The domain of nursing therapeutics is defined as all nursing activities and actions deliberately designed to care for nursing clients (Barnard, 1980). These include the social interventions and interpersonal actions which assist patients and families in coping with illness, with a focus on the characteristics and outcomes of these interventions, and the psychosocial circumstances under which they take place.

It is well known that the psychiatric/mental health nurse cannot rely wholly on technical means of providing care. The nurse must rely on the domain of interaction which is a central component of nursing in that patients are in constant interaction with their environments of which the nurse is part (Rogers, 1970). As well, interaction is the medium through which the nurse assesses patients and the instrument which guides the provision of therapeutic interventions and care (Meleis, 1991). Thus, the nature of the nurse-patient interaction, apart from the functional tasks of containment and pharmacotherapy, is crucial to successful outcomes in the care of the mentally ill. Contained in the need to understand the interactional nature of the nurse-patient relationship is the idea of therapeutic use of self.

Role definition and social context have been identified as factors in determining the boundaries of the nurse-patient relationship. Peplau (1988) saw nursing as a blending of roles stating that "the nursing process was both educative and therapeutic when the nurse and patient had come to know and to respect each other, as persons who are alike, and yet, different" (p. 9). Further to this, she was of the opinion that the human mind develops in and through a social process or milieu into which the human organism is born. She advanced the idea that nurses are charged with the primary responsibility for development and improvement of the hospital unit as a social context so patient growth can take place (Peplau, 1988). This idea concurs with the earlier writings of Tudor (1952) who stated that the social context, as it determines and affects the nurse-patient relationship, has been insufficiently explored and taken into account in psychiatric/mental health nursing. She pointed out that although a certain nurse was able to establish an effective and satisfactory relationship with a patient, this work could be undone by other members of the unit staff, by the formal and informal social structure on the unit which tended to maintain the patient in his or her mental illness, by the interpersonal relationships among the staff members, and by the general institutional context. Tudor (1952), and later Peplau (1988), pointed out that there are certain limitations within the institutional context, and that it is nurses who have the highest level of influence on the perpetuation of this social context, for it is nurses alone who experience the temporal dimension of being always present with patients. It follows that nurses are part of the patient's "social context" (Peplau, 1988) or, analogously, the patient's "environmental field" (Rogers, 1970).

Further to the view of social context, or environmental field concepts, Kim (1987) has identified four sets of variables related to patient-nurse contacts for providing nursing care: (a) patient and nurse; (b) a social context for the interaction; (c) the nature of the interaction; and (d) patient health outcomes. She stated "there is a need to have an understanding of how the special nature of client-nurse interactions modifies sociological, social psychological, and communication theories" (Kim 1987, p. 107). It is evident that psychiatric/mental health nurses can benefit from the interpretation, modification, and application of pre- or co-existing theoretical formulations from other disciplines to understand the meanings imparted by caring for patients whose difficult behaviour may be, or is, the illness itself.

In a clinical vignette, Peplau described an hostile patient and stated "it is difficult to accept a patient as he is when his hostility is constantly expressed seemingly in order to sever his relations with others. Actually, the hostility serves to protect the patient against further threats to his personality" (1988, p. 234). Thus the mental process of a defense mechanism is described and interpretation of the communication is invited from the nurse. The response of the nurse is speculated to be hopelessness but Peplau has explained "the situation is not hopeless until nurses think it is, for they will then relate to the patient in ways that communicated to him their inability to accept him as a person despite his hostile feelings" (1988, p. 234). In this elegantly simple explanation, Peplau has named a process in the nurse which, if activated in a particular nurse or group of nurses, can be interpreted through the psychological concept of countertransference.

Nurses are expected to meet the patient's needs. Doing so involves a process of considering the subjective meaning of an experience to the patient, assessing the influence of bio-psycho-socio-cultural variables on that meaning, assessing the possible consequences of the experience for the person, assessing how the person is adapting to the experience, and determining how the nurse can best help the person to cope with the experience, if it is necessary to do so (Meleis, 1991). The successful execution of this process demands an understanding of a framework from which to base opinions, particularly when the patient may not know or be fully conscious of the subjective meaning of the experience. Meleis (1991) has identified coping and adapting as both multidisciplinary and interdisciplinary concepts. The concept of countertransference is a suggested addition to this list because it is a concept with wide utility in understanding impediments to therapeutic interactions between nurses and patients.

Groves (1978) commented that psychiatry was unhelpful to the rest of the medical profession in providing insights into dealing with hateful patients, which was all the more puzzling in that psychiatrists had been fascinated by these patients since the turn of the century. Although the nursing literature lags behind the medical literature in the area of difficult patients, there is increasing evidence that nurses seek to understand their responses to hateful patients, or more broadly, patients who arouse uncomfortable feelings in nurses. Kelly & May (1982) have suggested that nurses like patients who validate the nurse's professional role. Alternately, therapy with the mentally ill may cause strain on the professional role (Winnicott, 1960). It may be that the strain to the professional role of nurses which results from caring for the mentally ill, is due, in part, to the ability of the mentally ill to provoke uncomfortable feelings in nurses. These uncomfortable feelings can be conceptualized as manifestations of countertransference.

Again, as Peplau (1988) suggested, the boundaries between the educative and therapeutic roles of the nurse have blurred over time. Bradley (1990) further illustrated this idea by putting forth the proposition that the treatment of the mentally ill requires both pharmacotherapy and psychotherapy which call for different interpersonal styles on the part of the therapist. Pharmacotherapy requires an approach which is active, directive, authoritative, concrete, and at times, coercive. However, results often occur within a short time span. Alternately, psychotherapy requires an approach which is more passive, nondirective, withholding, and empathically nurturing. The benefits from psychotherapy are not readily apparent within a few weeks, requiring patience and an ability to delay gratification on the parts of both the therapist and the patient. In addition, the conflicting roles of psychotherapist and pharmacotherapist are further complicated by the addition of role requirements inherent in activities designed to control the behaviour of patients such as those involved in certifying patients under mental health legislation, containing patients, controlling smoking and other activities, controlling aggression, limiting visitors, and enforcing unit rules. Certainly, role conflict has been identified by nurses who press charges against patients who assault them (Poster & Ryan, 1987). It is obvious that nurses working with the mentally ill must be able to act in various roles, often in rapid succession, to deal with the multiple and varying demands of the treatment setting and the clientele. Role conflict, then, can be seen as a contributing factor to the genesis of countertransference. Thus, if nurses are to have an interaction-based therapeutic role with patients, they must be aware of their own reactions to all patients but especially with those who require the execution of several roles. This is particularly true when nurses deal with patients to whom they have strong reactions of any kind. The force of an emotional reaction to a patient can threaten the tenets of professional standards of care, and a nurse's self-image as it relates to his or her own ideas about professional conduct. Aamodt (1982) has suggested that we have yet to confront the full potential of caretaking as a human response. Countertransference is a human response which stems from caretaking, and as such, has utility in the evaluation and understanding of nurse-patient interactions.

The concept of countertransference had been largely confined to the field of psychoanalysis since its initial description by Freud in 1910 (Freud, 1959). However, in 1970, Sandler, Holder and Dare suggested that the concept of countertransference could be readily extended outside psychoanalytic treatment and that awareness of countertransference could be regarded as a useful element in any therapist-patient relationship. These authors made the further observation that an awareness of countertransference was of potential value for all clinicians in monitoring their reactions to patients, and its use could be extended to include the monitoring by clinicians of the reactions of other members of the staff in a therapeutic institutional setting.

An exploration which examines if and how nurses experience countertransference in psychiatric settings is necessary because it has not yet been done. The body of literature on countertransference is replete with theoretical formulations, personal anecdotes, and descriptive writings. Several field studies are reported which describe observations of countertransference in nurses. However, no examination of the experience of countertransference in nurses by nurses has been conducted. This paucity of literature is of concern because the nursing literature often takes a moral tone in explaining how nurses are to recognize and deal with their countertransference without examining whether nurses are capable of recognizing it when it occurs. Correspondingly, this concern is compounded by theoretical controversy as to whether countertransference feelings are unconscious, conscious, or if the feelings gradually come into consciousness (Heimann, 1960), and whether countertransference originates in the patient or in the clinician (Jacques & White, 1988; Kernberg, 1965). A final concern is whether institutional settings contribute to countertransference. That the institution has a role in the genesis of countertransference was suggested by Stanton and Schwartz (1954) and Kaplan (1986), who indicated that, although patients are thought to cause splitting in treatment teams, this may only reflect intra- or inter-staff splits that are already present so that the patient becomes a victim rather than an agent of splitting.

A thorough understanding of the concept is a necessary prerequisite to accepting it as a meaningful, informative response which will aid in understanding the dynamics of the nurse-patient relationship. How countertransference feelings come into cognition, and how they are understood and processed, have not been studied, nor has there been an attempt to ascertain whether nurses understand if and how countertransference feelings affect their ability to care for patients.

Chapter 2

Literature Review

Classical View of Countertransference

Countertransference is a concept founded in psychoanalytic practice. Freud first described countertransference in 1910 and said it was a manifestation of the unresolved conflicts of the analyst and that more personal analysis would solve the problem of countertransference (1959). In 1924, Stern published the first essay on countertransference. He described countertransference as having two parts: (a) the analyst's unresolved issues; and (b) the analyst's response to the patient's transferences. In 1933, Reich emphasized that possible emotional damage could occur to the therapeutic relationship if analysts were not aware of their emotions (1949). He described a situation in which an analyst who was not able to control his sadistic impulses could easily fall into a silence which determined the enemy to be the patient who did not want to get well.

The belief that countertransference resided in the unresolved issues of the therapist may have contributed to the paucity of discussion about countertransference in that admission of such feelings might expose analysts as personally and professionally weak (Irvine, 1988; Racker, 1953: Semrad, Menzer, Mann, & Standish, 1952). As early as

1939, Fenichel hinted that perceived resistance to treatment could cause a reaction in the therapist: "whenever one is blocked in any piece of work to which one is devoted, one always becomes angry" (p. 185). He also suggested that fear of countertransference should not lead to the suppression of all human freedom in reactions to patients.

Further illumination of the dynamics of countertransference were provided by Sullivan (1940) who viewed countertransference as a parataxic distortion of present experience based upon the previous experience of the perceiver. Although Sullivan focused more on the parataxic distortions occurring in the patient's perception of the therapist, each recurrent recognition of a particular parataxic distortion brought forth more data as to the historic, personal source of the distortion within the patient. Bellis (1988) translated this into bioenergetic terms, stating that people see reality through the lenses of formative experiences. He postulated that persons under stress perceive as well as respond in terms of their character, often automatically and unconsciously. It can be assumed then that these parataxic distortions would occur within both the nurse and the patient in a therapeutic interaction.

Totalistic View of Countertransference

Klein (1946) first described the processes of splitting and projective identification as the part of countertransference that originates in the patient. Although she was describing an intrapsychic mechanism within the infant's fantasy rather than an interpersonal mechanism, subsequent writers have interpreted her work further. Segal (1964) stated:

> In projective identification parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts. Projective identification has manifold aims: it may be directed towards the ideal object to avoid separation, or it may be directed towards the bad object to gain control of the source of danger. Various parts of the self may be projected, with various aims: bad parts of the self may be projected in order to get rid of them as well as to attack and destroy the object, good parts may be projected to avoid separation or to keep them safe from bad things inside or to improve the external object through a kind of primitive projective reparation. (pp. 27-28)

Jacques and White (1988) stated that in psychotic disorders, the identification of an object with the hated parts of the self contributed to the intensity of the hatred directed against the external objects (other people). The implications of this mental process were further elucidated by Berman (1949) who postulated that the analyst, under the stress of the projected hatred, must resist tendencies to react to the patient in ways similar to the manner in which the patient's parents reacted to the patient. It was only through a demonstration by the analyst of genuine dedication and reasonableness that the patient could be put in the best place to learn to discriminate between childhood figures of the past and persons in the present (Berman, 1949). Grinberg (1962) stated that if the therapist could not make therapeutic use of objective countertransference data, he or she was involved in projective counter-identification. The therapist, without being consciously aware of it, fully experienced him or herself as he or she was portrayed in the patient's projective identifications and was unable to prevent him or herself from being what the patient unconsciously wanted him or her to be.

Winnicott (1949) agreed that the patient's projective identification triggered countertransference in the therapist. He felt that real, objective reactions to patients could be very powerful and, if used properly, were appropriate to the course of treatment. The patient required the analyst's ability to tolerate both the patient's and analyst's strong and deep feelings. It should be noted that many of these early authors worked primarily with psychotic patients, who behaved in primitive ways and thus had the ability to provoke intense reactions, including hate, in the therapist (Winnicott, 1949). Winnicott (1949) recognized the heavy emotional burden of caring for the mentally ill patient, particularly on the nurse, causing him to state "one can forgive those who do this work if they do awful things" (1949, p. 69). Conversely, he emphasized that those psychiatrists who did not practice psychoanalysis, should nonetheless have some understanding of the violent emotions patients could arouse in them. This understanding would avoid the situation where hate and fear were the driving factors behind treatment choices, or in other words, therapy directed towards the needs of the therapist rather than to the needs of the patient. Bion (1957) added a further caution in saying that projective identification was a mechanism by which a patient split off a part of the personality and projected it into the object where it became installed, sometimes as a persecutor, leaving the psyche, from which it had been split off, correspondingly impoverished.

Both Heimann (1950) and Little (1951) agreed that countertransference was interactional in nature, and both took the stance that all feelings and attitudes of the therapist to the patient were countertransferential. Heimann felt that the training and analysis of the analyst was directed toward enabling the analyst to sustain the feelings aroused by the patient instead of discharging them. Heimann (1950) was of the opinion that the analytic situation had not been sufficiently stressed as a relationship between two people which was differentiated from other types of relationships not by the presence of feelings in one participant, the patient, and the absence of feelings in the other, the analyst, but the degree of the feelings experienced, and the use made of them. She further stated "from the point of view I am stressing, the analyst's counter-transference is not only part and parcel of the analytic relationship, but it is the patient's creation, it is part of the patient's personality" (Heimann, 1950, p. 83).

The acceptance of the idea that the projective identification of the patient could provoke intense countertransference reactions in the therapist, led several authors to believe that countertransference was central to the therapy process (Heimann, 1950; Klein, 1946; Little, 1951; Racker, 1957; Winnicott, 1949) and that the patient had a role in revealing the countertransference to the analyst (Little, 1951).

Of special interest to nursing is Racker's (1953) assertion that, in the case of a patient who refused to take medicine that would cure him, it would be understandable for a doctor to get angry at the patient (experience countertransference feelings) but not a psychologist, who would presumably understand that the rejection of the medication was a symptom of psychological conflicts. In nursing practice today, there would certainly be an attempt by the nurse to understand the patient's explanation of why the medication was refused. Winnicott (1960) had stated that there was much fuller use of transference phenomena in psychoanalysis than in other disciplines. Therefore, he felt that the analyst role had a therapeutic advantage in interpreting transference as opposed to other professional roles. For example, a statement from a patient; "you remind me of my mother", would not necessitate any interpretation from a member of another discipline because the professional role did not include interpretation of such remarks. Again, in a therapeutic relationship between patient and nurse in a psychiatric setting, this statement would require interpretation, particularly if strong feelings were evident in the patient. Further, if projective identification was occurring from patient to nurse, the nurse might well take on the projected mother role, be it good, bad, nurturing, punishing, depriving, or engulfing.

Weigert (1954) postulated that a certain tension between the ideal of positive countertransference and its realization in daily professional performances was present within the confines of the therapeutic relationship. He felt this tension had the potential to elicit anxieties, or defenses against anxieties, in the analyst. As the anxiety of the analyst could interfere with the freely hovering attention of the analyst, it could also interfere with either the partial identification of the analyst with the patient, or empathy, the intuitive grasp of the real mental state of another person. He felt that to evaluate the information gained from empathy, the analyst had the imperative to be aware of the danger of the subjectivity involved in the process of identification, particularly as it related to any form of prejudice on the part of the analyst, as empathy and prejudice were considered to be absolutely incompatible. The dangers of subjectivity were further elucidated in Weigert's (1954) description of the polarity in the relationship of the analyst to the patient: the polarity between participation and observation, transference and real relationship. The idea that ideal positive countertransference was, in fact, empathy, was suggested by Money-Kyrle (1956). It was also suggested that without unconscious countertransference there would be neither empathy nor analysis itself (Little, 1960). The term concordant identification was coined to describe the disposition to empathy as the part of the countertransference that springs from the sublimated positive countertransference, which relates empathy with countertransference in the wider sense (Racker, 1957). Kernberg (1965) agreed with this formulation and considered that, while under the influence of concordant identification, the analyst experienced in himself the central emotion that the patient was experiencing simultaneously, and that empathy could be considered a direct expression of concordant identification.

The tension in the therapeutic situation described by Weigert (1954) was further clarified by Heimann (1960) who attributed the analyst's disturbed feelings in the countertransference to a time lag between unconscious and conscious understanding. This meant that something the analyst perceived passed without conscious awareness out of the realms of the conscious ego, and therefore became inaccessible. This inaccessibility could be partially corrected by self-analysis on the part of the analyst in asking why the patient was doing this at this time, and trying to elicit meanings in the behaviour, either contained in the patient's past, or in the past interpretations of the analyst (Heimann, 1960).

Thus, two schools of thought about the source of countertransference reactions have evolved. A totalistic approach was proposed by Kernberg (1965), who agreed with Racker (1957) and Winnicott (1949) in considering the emotions of the therapist toward the patient as having been created in part by the patient's psychopathology. This was not to rule out the more classical perspective that countertransference could be viewed as originating in the unresolved conflicts from the past life of the therapist, but that countertransference could be viewed as a natural and expected emotional response elicited in the therapist in the context of the relationship with the patient.

The addition of a more holistic perspective of countertransference has led to the view that countertransference reactions in the therapist are useful to the therapy, and may even be used diagnostically (Jacques & White, 1988). However, Racker (1957) cautioned that countertransference could not supply the pure truth about the patient because of the distortions possible in the analyst. A further caution was added by Heimann (1960) who felt that countertransference was often misinterpreted as any reaction to the patient and that reactions could only be verified against actual data. Further to this, Sandler

(1987) has suggested that the differentiation of what belongs to the patient and what belongs to the analyst was likely to remain as a difficult technical problem.

Criticism of the totalistic approach includes the concern that broadening the term countertransference to include all emotional phenomena in the therapist is confusing in that it has made the term countertransference lose all specific meaning, and that it tends to exaggerate the importance of the analyst's emotional reaction, with a detrimental shift away from the desired position of neutrality (Kernberg, 1965). Criticism of the classical approach centres around concern that restricting the definition of countertransference to emotions residing in the unresolved conflicts of the therapist implies that experiences of countertransference are somehow wrong (Kernberg, 1965). As well, important information about the nonverbal communication between therapist and patient can be obscured when therapeutic efforts are directed toward eliminating the therapist's emotional reactions rather than focusing on their reality and sources (Kernberg, 1965).

Kernberg (1965) saw countertransference reactions on a continuum, ranging from those related to neurosis on one extreme to psychosis at the other. He asserted that as the patient presented toward the more extreme end of the psychotic continuum, there was greater contribution by the patient to the countertransference of the therapist, gradually displacing the importance of those countertransference aspects which arose from the therapist's past.

The lack of a single conceptual framework to address countertransference was identified by Lakovics (1983) who attempted to classify countertransference responses into six categories. Included in Lakovics' six categories were concordant and complementary responses (Racker, 1957), as well as the classical response (Freud, 1959). Lakovics' (1983) hypothesized additions included: (a) interactional reactions which were defined as conscious responses to something the patient was saying or doing; (b) life events of the therapist that could produce sadness interpreted by the patient as rejection; and (c) institutional countertransference (Gendel & Reiser, 1981) which resulted in feelings of impotence and unimportance in the therapist.

Countertransference in Clinical Situations

Countertransference has been identified as contributing to the dynamics of the therapist/patient relationship in a variety of clinical situations. In situations of patient aggression toward nurses, countertransference is seen to either provoke violence in that it stems from the nurse's need to control the patient and can result in unnecessary harshness toward the patient (Herzog, 1992), or to contribute to the nurse's subsequent avoidance of the patient, once the violence has occurred (Katz & Kirkland, 1990). In a retrospective chart review with a sample size of 74, Virkunnen (1974) found that 44.6 percent of victims of people who had chronic mental illnesses had displayed at least a partially rejecting attitude toward the patient in a period of time prior to the assault. This finding led the author to conclude that there was a probability that the rejecting attitude of the victim was at least a partially contributing factor in the development of hostility in the aggressor, and that hostility ultimately culminated in violence. This is supported by the view that frightened staff may act authoritarian and increase the patient's feelings of helplessness, thereby inadvertently provoking more violence (Dubin, 1989). Further, verbal threats may raise deeper countertransference issues than does physical aggression (Maier, Stava, Morrow, Van Rybroek, and Bauman, 1987). However, there is some reluctance to include countertransference as part of the conceptualization of patient violence because it is embedded in a theoretical base to which some nurses do not ascribe (Morrison, 1992).

Generally, patients who are perceived as hopeless and helpless, and as having a poor prognosis, have been identified as provoking countertransference reactions in caregivers (Book, Sadavoy, & Silver, 1978; Colson et al., 1985). The application of the term manipulative to describe patients has been understood to derive from strong countertransferential feelings and may greatly affect approaches to care (Mackenzie, Rosenberg, Bergen, & Tucker, 1978; Vogel, Nihart, Buckwalter, & Stolley, 1987). As well, patients who differ with the staff's wishes are the most likely to be labeled manipulative (Fontana, 1971).

Countertransference has been identified as a factor in therapeutic relationships in the following clinical situations: The developmentally-disabled adult (Godschalx, 1983); patients with AIDS (Dunkel & Hatfield, 1986); couples therapy (Jones, 1987); the pregnancy of the therapist (Comeau, 1987-1988); patients with personality disorders (Ashton, 1990; Bach-Y-Rita, 1974; Burnham, 1966; Grunebaum & Klerman, 1967; Kaplan, 1986; Lego, 1988; Main, 1957; Sebree & Popkess-Vawter, 1991; Reiser & Levenson, 1984); the elderly patient (Galanti, 1992; Poggi & Berland, 1985); the emergency room patient (Hanke, 1984); and, schizophrenic patients who are subjects in clinical research trials which involve the administration of placebos (Paternostro, 1991).

Countertransference and chronically mentally ill patients.

Young adult, chronically mentally ill patients have begun to emerge as a focus of concern for mental health professionals predominantly because of the onset of their illnesses in an era of deinstitutionalization (Bachrach, 1982). These patients often do not complete treatment programs because they are difficult to engage, tend to use emergency departments as treatment facilities, and travel from one agency to another, thereby ensuring that continuity of care does not occur (Bachrach, 1982; Glick, Klar & Braff, 1984; Sheets, Prevost & Reihman, 1982). The patients are further described by Bachrach (1982) as having patterns of interaction that are highly affect-laden resulting in an almost instantaneous transference reaction which in turn generates serious countertransference in their therapists.

Neill (1979) stated that patients perceived to be difficult were often unofficially blacklisted and were described in pejorative terms such as manipulative, a pain, or inappropriate. He felt that these patients were able to engender strong negative feelings in staff including fear, anger, and helplessness. Seventeen patients who were rated as difficult by staff on a checklist of difficult behaviours, were compared to a control group of 26 patients who did not meet the criteria for being labelled difficult.

Of note is that each difficult patient was simultaneously referred to or involved in two or more treatment programs without coordination between them, had no one worker who was clearly responsible for coordinating treatment programs, had incomplete documentation of treatment contracts, and lacked a comprehensive treatment plan. This finding supports the views of Colson et al. (1985) who felt that patients identified as difficult were often perceived as improving less and having a poor prognosis. The application of the label manipulative to this group of patients may greatly affect approaches to their care (Vogel, Nihart, Buckwalter, & Stolley, 1987). Conversely, patients who differ with the staff's wishes are the most likely to be labeled manipulative (Fontana, 1971).

Schizophrenic patients in particular have received attention because of their intense psychotic anxiety, hatred, dependency, distrust, and loneliness (Kahn, 1984; Savage, 1961). A study of 127 patients assessed on the Hospital Treatment Rating Scale, delineated the category of patients suffering from withdrawn psychoticism as being perceived by respondents as most difficult to treat in that the patients did not respond to interpersonal approaches (Colson et al., 1985). Subsequent analysis of the same data resulted in the conclusion that conventional diagnostic labels have relatively little bearing on the degree of treatment difficulty (Colson et al., 1986a).

In later work analyzing the same data, Colson et al. (1986b) measured provoked responses to these patients by various subgroups of the health care team. Character pathology was most strongly associated with a provoked response of anger, and withdrawn psychoticism was most strongly associated with a provoked response of helplessness. Violence-agitation evoked a high degree of helplessness in nurses and a high degree of anger in activity therapists. As a subgroup, social workers and psychiatrists displayed similar ratings on affective responses to patients in general, but overall, the ratings of affective responses were less than those experienced by nurses and activity therapists as a subgroup. This finding may have reflected the practice of psychiatrists and social workers in meeting with patients in offices away from the units, whereas nurses and activity therapists were in greater daily contact with patients over time. Although the findings are not generalizable because of possible differences in staffing levels, policies, culture, history of assaults, and the use of seclusion rooms in other facilities, the staff's proximity to patient behaviour may be a factor in staff response to patient behaviour.

Countertransference and patients with borderline personality disorders.

The use of the term personality disorder, or borderline in particular, may reflect pejorative attitudes on behalf of nurses indicative of a tendency to use the diagnosis in response to an unconscious dislike for the patient or the need to rationalize treatment failures (Reiser & Levenson, 1984). These authors suggested that the term borderline can lose all diagnostic meaning and become a colloquial expression of contempt in the same category as the terms gomer, turkey, and crock, and result in breakdown in empathy between therapist and patient. Holden (1990b) has suggested that labelling any patient with a diagnosis alone is a manifestation of the emotional withdrawal of a countertransference reaction.

Included in the diagnostic group of personality disorders are patients who self-injure. Self-injuring behaviour presents unique management challenges to nurses and can evoke extremely strong countertransference reactions, including anxiety, guilt, anger, inadequacy, and an urge to retaliate (Bach-Y-Rita, 1974; Sebree & Popkess-Vawter, 1991). As well, labelling these patients as manipulative or attention-seeking tends to obscure the psychopathology of the behaviour and provokes disagreements within the treatment team as to treatment protocols

(Grunebaum & Klerman, 1967). Thus, the difficulty in providing appropriate treatment is compounded by the level of countertransference reaction in the nurses.

There is evidence to suggest that patients with borderline personality disorder often provoke the most severe countertransference reactions in mental health staff. Their psychological make-up is primitive, leading them to engage in rapid transference reactions, and as a result, staff members tend to experience intense and primitive emotions relating more to the impact of this transference than to their own psychological make-up (Book, Sadavoy, & Silver, 1978; Kernberg, 1975; Lakovics, 1985). Conspicuously, the mechanism of projective identification from the patient can cause the staff who receive the bad, split-off projections to become more punitive, and the staff who receive the good, split-off projections to become over involved (Adler, 1973; Katz & Kirkland, 1990; Kernberg, 1965). Patients with borderline personality disorder are prone to verbally devalue their caretakers which can threaten one's sense of professional identity (Adler, 1970). One of the most difficult issues in dealing with patients with borderline personality disorder is negative countertransference which contributes to many unpleasant feelings in the nurse who must identify and accept the feelings and then use them in therapy (Lakovics, 1985;

Platt-Koch, 1983). Zetzel (1971) recommended that psychotherapeutic contacts with patients with borderline personality disorder should not exceed one hour a week. This recommendation is impossible for nursing staff who often have multiple contacts with many patients in the course of a shift and over the length of an admission.

The ability of the patient with borderline personality disorder to cause splitting within the treatment team on psychiatric units is well described (Adler, 1970; Book, Sadavoy, & Silver, 1978; Burnham, 1966; Kaplan, 1986; Kernberg, 1965; Lakovics, 1985; Mackenzie, Rosenberg, Bergen, & Tucker, 1978; Main, 1957). Awareness of splitting must be understood in the context of the countertransference phenomena precipitated by it (Gallop, 1985). This author warned that splitting has become part of the jargon of the borderline patient and that to successfully negotiate the countertransference response to splitting, and progress beyond labelling, nurses must become aware of their part in the process. This lack of awareness is further hampered by the unconscious nature of countertransference and results in individual nurses thinking their reactions are normal and correct and that everyone else is wrong. However, splitting may have the seemingly paradoxical effect of indicating treatment success in some cases, in that the ability of the patient to attract an advocate can be a favourable prognostic sign (Silver, Cardish, & Glassman, 1987). A recommended strategy for dealing with splitting is the use of a consistent nursing approach whereby the nurse recognizes projective identification and reflects it back to the patient to provide ego boundaries (Freeman, 1988).

Countertransference and Nursing

There is evidence in the body of nursing literature that countertransference is gaining acceptance as one means of understanding the dynamics involved in working with severely psychologically disturbed patients (Ashton, 1990; Bonnivier, 1992; Sebree & Popkess-Vawter, 1991). Despite the acceptance of the concept of countertransference into nursing, some authors have continued to use it in its classical sense only. Countertransference is conceptualized as a problem within the nurse without considering the effects of the patient's behaviour in invoking it (Lego, 1984; McMahon, 1992; Schroder, 1985).

However, the meaning of countertransference has been extended to include the past entering into the here-and-now aspects of the relationship, as occurring later in the therapy than transference, and occurring within the context of an established relationship because it includes the patient's reactions and material (Schroder, 1985). Both positive and negative countertransference reactions have been discussed as resulting in either oversolicitous or distancing behaviour by the nurse (Schroder, 1985). Labelling the patient as manipulative, thereby allowing behaviour to be interpreted as willful, or in contrast, believing that a warm, positive relationship will foster trust with all patients, thereby allowing the nurse to entertain feelings of omnipotence or have rescue fantasies, are all manifestations of countertransference reactions (Mark, 1980).

Transactional analysis classifications have been suggested as a useful framework for understanding how one experiences countertransference feelings for the patient and what triggers it in the nurse (Haber, 1989). Countertransference has been conceptualized as residing in the psychopathology of the patient but the strength of the reaction is mitigated by the manner in which staffs' past needs and conflicts influence their reactions to the clinical situation (Venn & Derdeyn, 1988). Several configurations of countertransference phenomena have been described and may be conceptualized under the aegis of individuation issues which manifest themselves in the resistance of the nurse to the patient's shift to independence (Lego, 1990).

Identification with patients is understood to differ from countertransference in terms of the complexity and consciousness of the nurse's reaction (Relling-Garskof, 1987). Identification may occur in such conceptually simple situations as the nurse being the same age as the patient. What differentiates identification from countertransference is the processing of feelings such as depression or anger following interactions with the patient, feelings of the need to impress the patient, feelings of omnipotence in caring for the patient, and unnecessary sharpness in interactions with the patient up to and including continual arguing (Relling-Garskof, 1987).

McMahon (1992) felt that discrepancies between nurses' overt communication and their inner feelings derived from failure to recognize and incorporate countertransference. Further, nurses were urged to use self-assessment and introspection to understand and modify forces within the self that have the potential to inhibit the nurse-patient relationship.

It has been suggested that the number of psychological conflicts present on an inpatient unit are exponential, and that attempts to deal with these on a one-to-one basis are not beneficial (Dubin, 1989). Several authors concur with the opinion that countertransference feelings can be processed in team meetings (Brobyn, Goren, & Lego, 1987; Di Bella, 1979; Gallop, 1985; Maier, 1986; Piccinino, 1990; Witherspoon, 1985). Bonnivier (1992) facilitated a peer supervision group experience in which nurses planned care approaches directed toward contracting, limit setting, confrontation, and the avoidance of collusion with patient behaviours. However, peer support groups or team meetings have the imperative to provide a level of safety to nurses in order that openness and honesty in disclosure of feelings about patients is encouraged (Johnson & Silver, 1988). Dubin (1990) recommended that expressions of feelings about patients should be taken at face value and that staff members should expect to receive support from their peers. However, it must be recognized that simply identifying countertransference reactions does not necessarily lead to resolution (Schroder, 1985).

A dissenting opinion about the value of team meetings to resolve countertransference was voiced by Abrams and Sweeney (1982). These authors were of the opinion that unstructured staff meetings which emphasized self-expression could indirectly undermine the work of the unit by allowing the emergence of intensely hostile feelings and individual psychopathology. Identifying countertransference as residing in the unresolved conflicts of the nurse is liable to be met with defensive postures. Further, there must be a provision that the supervisor or leader of the group not provide therapy to the staff (Goin & Kline, 1976).

Countertransference, empathy, and caring.

Forsyth (1980) described empathy as: (a) occurring in consciousness; (b) implying relationship; (c) involving validation of experience; (d) existing in variable degrees of accuracy; (e) having temporal dimensions restricted to the here and now; (f) involving energy which varies in intensity; (g) requiring objectivity; and (h) requiring freedom from judgment or evaluation. This taxonomy is congruent with the concept of countertransference in the following areas: (a) both imply relationship; (b) both involve validation of experience; (c) both exist in variable degrees of accuracy; and (d) both involve energy which varies in intensity. Where Forsyth's conceptualization of empathy differs from countertransference is that: (a) empathy is conscious and although countertransference can occur in consciousness, it is largely unconscious; (b) empathy has temporal dimensions restricted to the here and now whereas countertransference is a product of past relationships and conflicts; (c) empathy requires objectivity but any feeling in the range of countertransference reactions except concordant identification is a subjective response; and (d) empathy requires freedom from judgment or evaluation whereas countertransference can be synonymous with judgment.

Similarly, caring has been described as a mental and emotional process that evolves from deep feelings for the patient's experience but has the potential to increase the personal vulnerability of the nurse leading to dilemmas in caring too little or too much (Forrest, 1989). Dangers in the caring process are attributed to the nurse's own background, learning, feelings and responses to patients, frustrations encountered in the work, and the effort of confronting and handling one's own limitations (Forrest, 1989). The dangers in the caring process compare to descriptions of countertransference issues in the nurse-patient relationship.

One nurse author has defined empathic projection as a healthy form of projective identification as contrasted to sympathy which arises out of overidentification, overinvolvement, and subjective attachment (Holden, 1990a). Further, when empathic feelings are absent, countertransference is present in the nurse-patient relationship (Holden, 1990a). Extending the observations of Tudor (1952) and Hall (1976), Holden stated that physical withdrawal by the nurse from the patient inhibited the possibility of establishing a therapeutic relationship which may have enhanced the nurse's own professional growth. A further observation was that the proclaimed role of the nurse as patient advocate may, in fact, be a manifestation of countertransference, and that nurses need to examine both transference and countertransference in terms of the influence these processes impose within the domain of professional relationships (Holden, 1990a).

In a later publication, Holden (1990b) suggested that effective management of oneself as a health professional required a clear conception of the extent to which one is responsible for the recipient of caregiving, the ability to set limits on the extent and emotional intensity of the care delivered, and an awareness of which problems belonged to the self, and which belonged to the patient. The ability to maintain nonpossessive warmth, genuineness, and accurate empathy with difficult patients over long periods of time requires that the nurse understand his or her reactions and feeling states (Lakovics, 1983). Ricci (1991) has suggested that an empathic approach may guide the nurse to avoid labelling a patient as manipulative and instead, interpret anger as an intense, internal sequence which cannot be managed by the patient (Ricci, 1991).

Nurses, when compared to psychotherapists using Kernberg's (1965) countertransference reactions, may also regress and exhibit immature character traits when dealing with difficult patients, resort to emotional withdrawal from patients by requesting a change in patient assignment, adopt an attitude of dedication to patients when their sympathy is aroused, and/or experience envy and feelings of destructiveness when patients are perceived to receive care that they themselves desire (Holden, 1990b).

Countertransference, empathy, and psychiatric/mental health nursing.

Two studies have been conducted to determine whether psychiatric nurses, when compared to other nurses, display more empathy, and whether certain patient groups evoke more or less empathy from nurses. In an exploratory study with a sample size of 70 nurses and 70 patients, the scores of psychiatric nurses were not significantly different on the variable of experienced empathy than the scores of medical, surgical, and orthopedic nurses (Forsyth, 1979). However, psychiatric nurses were perceived by patients as being more empathic than the other three groups of nurses (Forsyth, 1979). This finding led to the supposition that psychiatric nurses may be capable of making empathic responses without actually experiencing empathy.

Emotional empathy was measured in a study with a within-subject experimental design (Gallop, Lancee, & Garfinkel, 1989). A sample of 93 fourth-year nursing students were asked to respond to two hypothetical schizophrenic patient and borderline personality disorder patient sets. Criterion validity was established by comparing total empathy scores obtained on the Staff-Patient Interaction Response Scale (SPIRS) with the Questionnaire Measure of Emotional Empathy (moderate but significant phi correlation coefficient of .67). As well, 15 expert clinicians rated the level of empathy reflected on 10 sample responses (phi correlation of .78 obtained when experts' rankings were compared with the investigators' rankings using the SPIRS). The results showed that a significant proportion of nurses displayed a lower level of empathy toward the hypothetical borderline patients. The finding of contradictory responses toward borderline patients was interpreted as constituting defensive behaviour that inhibited involvement and signified disruption of the empathic process. Affective involvement was more likely to be displayed toward hypothetical schizophrenic patients who were perceived as ill. This led the authors to conclude that the role of nursing staff in relation to these patients is confirmatory and clear which concurs with the opinions of Kelly and May (1982). Nurses may find it safer to become involved, even at the affective level, with schizophrenic patients because they receive therapeutic validation in return for their involvement (May & Kelly, 1982).

Countertransference and care issues in psychiatric/mental health settings.

Early nursing authors have struggled to understand the phenomena of disliked, problem, or withdrawn patients. In two reported case studies, Tudor (1952) described a process that had occurred between patient and nurse. The inability of the nurses to make any kind of meaningful contact with the patient, who displayed rejecting behaviour, occurred in concert with ever increasing withdrawal of nursing attention, of which the nurses were unaware. Instead, the process was rationalized as the inability of the patient to tolerate closeness. Tudor attributed the feelings of apathy and guilt in the staff to repetitive experience of failure with these patients, which may have prompted the nurses to label the patients as hopeless and helpless. Tudor (1952) labelled this process mutual withdrawal. However, a similar nurse-patient interactional pattern was identified by Stamm (1985) who named it benign neglect and considered it to be a manifestation of countertransference. Further, Climo (1983) described this type of translation of countertransference reaction into behaviours, as opposed to feelings and thoughts, as a countertransference trap.

In a field observation study conducted on a psychiatric unit, Hall (1976) observed that hospital staff were drawn to patients who participated in their treatment. If participating patients were similar to staff, a mutual liking occurred early in the course of hospitalization and staff tended to spend more time with these patients. Patients who could not draw attention to themselves did not receive recognition that led to nurse-patient interactions. These observations led Hall to speculate on the nature of the therapeutic relationship between patient and nurse, when the patient did not have the ability to attract a nurse into forming a therapeutic relationship. She concluded that the imperative of professional accountability should lead mental health professionals to examine more closely the outcomes of the care they provide patients, including patients who do not fit into established treatment programs. Hall (1976) did not differentiate between the therapist role and the nursing role.

In a later publication, Hall (1977) referred to a comprehensive review of the sociology literature on the variables of liking and attractiveness. She pointed out that these theories are of limited utility because of the discrepancies between social and therapeutic relationships, in that most professionals would not consider it acceptable practice to base care decisions on degree of liking. Hall (1977) also raised some questions about the current status of the norm of affective neutrality in the therapist, specifically as it relates to the ability to establish therapeutic relationships with patients who are dissimilar or unlikable. As well, she questioned the ability and willingness of the nurse/therapist to verbalize feelings of liking and disliking patients to peers.

In 1979, Hall and Mitsunaga pointed out that role prescription for what to do when a nurse dislikes a patient is virtually absent from the educational and clinical literature. Although no answers were provided, several questions were raised as to whether good relationships between patients and nurses led to good care, despite evidence that poor interpersonal relationships with patients led to tendencies in nurses to avoid problem or disliked patients, and whether or not nurses could be taught to have good working relationships with patients whom they did not like (Hall & Mitsunaga, 1979).

In a descriptive report of team meetings with nursing staff, Main (1957) elucidated the pattern of staff response to difficult or special appeal patients. He noted that patients were able to evoke in the staff a great desire to help, equally great distress and guilt at failing to help, feelings of massive responsibility for the patient's well-being, and omnipotent urges to rescue the patient from mishandling by others. This configuration of staff emotions and behaviour has also been named overprotectiveness (Stamm, 1985) and although this overprotectiveness was seen as the antithesis of benign neglect, it was nonetheless a manifestation of countertransference. Main did not use the term countertransference but did attribute the behaviour of the patients to their disturbed object relations, which they were able to reproduce by projective identification in the social context of the hospital unit.

Whyte, Constantopoulos & Bevans (1982) analyzed the responses of 11 nurses to 10 patients on a psychiatric unit by Q-analysis in an attempt to provide evidence that: (a) some nurses are characterized by the way they respond to patients; and (b) unusual responses are sometimes aroused in a nurse by a particular patient. The nurses completed an adjective checklist to capture the flavour of their interactions with the 11 identified patients over the length of stay. Criteria for choosing the patients were not given. The checklist was tested for neither reliability nor validity. One nurse was found not to experience the same negative feelings for one particular patient as the other nurses did. The authors concluded that this nurse was not in a position to use her feelings as an indicator of the difficulties the specific patient aroused in other interpersonal relationships. Another possible explanation is that the patient, by means of projective identification, was able to split the staff into good and bad factions, and it may have been this one nurse who received the good nurse projection (Katz & Kirkland, 1990).

Countertransference reactions are particularly unsettling when they are manifested in hatred for the patient (Maltsberger & Buie, 1974) or retaliatory fury (Adler, 1973). Truly bad countertransference feelings stem from the therapist's survival needs, are manipulative and heartless, and thus are not empathic to the feelings of the patient (Bellis, 1988). Negative countertransference can manifest itself on psychiatric units in such actions towards the patient as seclusion (Katz & Kirkland, 1990), sadistic control in contrast to therapeutic limit setting (Book, Sadavoy, & Silver, 1978), argumentative behaviour, pushing for discharge, or attempting to get the patient to leave treatment (Adler, 1972).

Johnson and Werstlein (1990) have suggested that the practice in nursing indexes of labelling patients as manipulative, problem patient, con artist, demander, dependent, and hateful, supplies a negative frame before the nurse can form an interpersonal relationship with the patient, and may in fact, act to stop such a relationship before it begins. These authors hypothesized that a broader understanding about the perception of patient behaviour may positively influence behavioural responses of nurses. They provided the following hypothetical clinical example: A patient expresses a desire to speak about his or her family. The nurse will generally respond favourably. However, should the patient engage in wrist slashing preceding a visit from the family, the nurse will rarely seek out the intention behind the behaviour (Johnson & Werstlein, 1990). A further interpretation of these dynamics might include the role of countertransference as interfering with the nurse's ability to process such an occurrence. Hagey (1984) has suggested that the interpretation of dramatic narrative must be preserved in nursing for problem identification, and that interactional approaches should provide the practitioner with codes or blueprints for negative interactions as well as positive interactions.

The effects of acting out behaviour by patients have been described as part of a cycle wherein acting out behaviour is followed by the attempts of the staff to stop the behaviour, which in turn is followed by escalating acting out behaviour by the patient (Loomis, 1970). The cycle is understood by Loomis (1970) to be driven by the reluctance of the nurses to recognize and admit their overwhelming and shameful feelings of anger and the desire to retaliate.

Adler (1972) expressed the view that we are willing to give to the patient, to be empathic, but that we expect something back. Although he was expressing a psychoanalytic perspective, this may hold true for all the helping professions. The art of being a good therapist consists in part of a sensitivity which can weigh how much a patient is genuinely overwhelmed and needs to nurtured, and how much a patient can stand to examine at a specific moment. Correspondingly, limit-setting contains a recognition of how much of it is appropriate, and how able the caregiver is in controlling the wish to behave in a punitive fashion. Adler (1972) felt that the good enough mother aspect of the therapist ultimately determined whether the patient had a corrective emotional experience as part of therapy, or a pathological experience similar to that of his or her early childhood. Appropriate limit-setting was seen by Adler (1970) to be an expression of empathy.

It has been said that to acknowledge that one does not like a patient is to deny one's professionalism since the basis of psychiatric nursing is to manage bizarre and demanding behaviour (May & Kelly, 1982). These authors rightly pointed out the deficiency in many patient problem typifications in not allowing for care of a patient whom one does not like. Further, the need to establish authority over patients is seen to derive from organizational needs and is genuinely perceived to be in the best interests of the patient. The readiness of the psychiatric nurse to put himself or herself at the disposal of a patient is conditional in the first instance on the patient in turn acknowledging, by implication at least, this readiness, and secondly, on the patient being regarded as properly in need of nursing care and attention (May & Kelly, 1982). In other words, the patient, by words, deeds, or condition, legitimates the nurses' therapeutic aspirations. Where these conditions apply, the patient is likely to be viewed positively by nurses, no matter how intractable the problems presented or how demanding the patient (May & Kelly, 1982). However, this argument does not provide an explanation of the situation in which the patient clearly rejects nursing care, displays verbal aggression, flaunts rules, and yet manages to be liked by nursing staff.

The body of literature on problem patients has been criticized as being linear and reductionistic in that it generally implies that a particular response in the nurse is caused by a particular behaviour or attitude of the patient. (Kelly & May 1982). Further, the possibility that human behaviour might be oriented towards its immediate social context is denied, ignoring the symbolic element in nurse-patient interactions which is a manifestation of the meanings imposed on the situation by the participants (Kelly & May, 1982). These authors argued that patients' behaviour and attitudes do not reside objectively in the patient; rather they reside in definitions attributed to them by staff. It may be that bad patients make the lives of nursing and medical staff difficult, as Kelly and May (1982) have stated. As well, analysis of the processes involved in the context of nurses, doctors, and patients interacting with each other under a variety of conflicting demands is seen as a legitimate focus for research (Kelly & May, 1982). Hagey (1984) has criticized the work of Kelly and May for suggesting an interactional approach to avoid problems without providing the practitioner with direction for dealing with negative behaviour.

The introduction of countertransference as a concept for nursing and nurses may invite criticism in that it applies a psychological/psychiatric framework rather than a nursing framework. Hoeffer and Murphy (1982) have questioned whether concepts described as originating in early child-parent interactions, and valued as key factors in psychoanalyst-patient interactions, are valid for nursing situations. However, an object-relations framework has been suggested as one means of analyzing data presented by patients, and developing a mirror image of the situation from the patient's perspective (Erickson, Tomlin & Swain, 1983). This is based on the idea that all patients have some form of object loss in connection with basic needs deficits. Thus, object-relations thinking, which is grounded in the totalistic view of countertransference, may be of value for nurses in developing an understanding of the psychodynamics of the nurse-patient interaction. It is clear that nurses are beginning to use the concept of countertransference to name and understand those feelings and values which nurses bring to interactions with patients, particularly in the absence of a nursing term which so fully describes that which is experienced.

Chapter 3

Purpose of the Study

A review of the literature supports the view that there are as yet, many undefined variables which contribute to the nature of the interpersonal relationship between the nurse and patient. While patients who are perceived as difficult are present in all areas of practice, it is those patients in psychiatric/mental health practice areas which have received the most attention in terms of a psychodynamic view of their behaviour. It is evident that patients perceived as difficult, for whatever reason, receive this designation largely because of their ability to arouse unprofessional or uncomfortable feelings in the nurse, which can threaten the professional role identity of the nurse. The introduction of the concept of countertransference into the nursing literature indicates a beginning acceptance of the idea that some part of the arousal of uncomfortable feelings has its genesis in the personality structure of the nurse. The personality structure of the nurse includes whatever the nurse brings to the therapeutic interaction, and whatever role the patient is successful in assigning to the nurse through the process of projective identification.

Although there is concern about whether it is appropriate for nurses to incorporate a psychological or psychiatric framework to nursing situations (Hoeffer and Murphy, 1982), it is obvious that there needs to be a way of understanding and naming the feelings aroused in the nurse during the course of daily interaction with patients. The term countertransference, with its attendant conceptual framework, may be of use to nurses in analyzing and understanding the dynamics of interactions. There is evidence to suggest that psychoanalytic thinking has had an influence on nursing theory. For example, Rogers' (1970) idea of human beings having environmental fields which interact with each other is analogous to Jung's (1983) conception of the interaction of two open systems in which difficulties in either signals the need for change in both.

To fully comprehend and perhaps gain some control over variables which influence the interaction of environmental fields or open systems, it is useful to examine the interactional patterns of patients with illnesses on the more disturbed end of the mental health spectrum. These patients may contribute to the countertransference of the nurse in increasing increments according to their level of pathology, and in such a way that it gradually displaces the importance of those countertransference issues which arise from the nurse's past (Kernberg, 1965). Melges and Swartz (1989) described a cybernetic model of the oscillations of attachment specifically as it pertains to patients with borderline personality disorder. Cybernetic is intended to describe processes of control governed by the feedback of information. It is the contention of this author that the feedback of information in either situation of nurse to patient, or patient to nurse, can be misinterpreted if communications are taken at face value and the nurse cannot interpret the symbolic meaning of either the behaviour or the verbalization. A patient with borderline personality disorder poses a particular difficulty in that the patient may be unable to articulate what is meant by help so that the concept of being helped cannot be placed in an interpersonal context from which to proceed with the work (Giovacchini, 1970). If nurses can understand, even intellectually, that arrogance can hide fear, that anger can cover despondency, and that patients can use these defense mechanisms in order not to think, feel, or remember, then the possibility of therapeutic success is enhanced.

Understanding countertransference in theory, and recognizing it in practice situations, are suggested means of interpreting symbolic communication. Not understanding the concept of countertransference may preclude the possibility of a therapeutic interaction and simply supply the patient with the same feedback received from everyone else in his or her social surround.

Mutual withdrawal or vengeful silence, omnipotence or helplessness, benign neglect, overinvolvement or overly solicitous care, retaliatory fury, and sadistic control are terms which have been used to describe the gamut of emotions provoked in various categories of health care providers. These terms have all derived from observations made by caregivers about other caregivers. As these feelings can be interpreted to encompass opposing edges of a feeling continuum, their very strength may inhibit their disclosure by nurses who are taught professional objectivity and detachment.

Empathy may be a form of positive countertransference. Alternately, negative countertransference may interfere with the ability of the nurse to provide empathy or caring. Further, the social context of the hospital unit may encourage or suppress the expression of countertransferential material. It is important for nurses to determine whether countertransference is an insurmountable block or a fact of life which may be used productively in therapeutic situations. This is particularly apt when seen against a backdrop of literature which considers countertransference to be a normal part of any therapeutic interaction (Kernberg, 1965).

Despite the emergence of the concept of countertransference for use in nurse-patient situations, there has been no investigation as to whether nurses have an understanding of this mechanism as it surfaces in their daily practice. Further, despite the personal anecdotal nature of some of the existing literature, there has been no systematic attempt to gain an understanding of whether nurses have any conception of countertransference as a factor in nontherapeutic interactions.

That psychiatric/mental health nurses participate in and direct therapeutic interactions is understood, but the limits of the therapeutic relationship vary considerably with the abilities of the nurse and his or her understanding of what the limits of this relationship are. As well, it must be acknowledged that there are many limitations inherent in the organizational structure of an inpatient care facility. In particular, psychiatric patients are generally limited to hospital stays of relatively short duration. However, since many patients come to hospital for treatment of what is essentially an acute exacerbation of their underlying chronic condition, each admission can be viewed as a piece of the whole treatment within a continuum of care (Silver, Cardish, & Glassman, 1987). This increases the imperative to provide therapeutic, rather than merely custodial care. As well, this view carries with it the probability that patients seen as being difficult on one admission will also be seen as difficult on subsequent admissions. Thus the feelings of hopelessness engendered in psychiatric/mental health nurses by so-called revolving door admissions can be reframed within a view of a continuum of caring.

Actions by nurses directed towards encouraging the patient to find treatment elsewhere (commonly referred to as greyhound therapy) are generally unsuccessful. This is in part due to the fact that physicians control admission to hospital beds, not nurses. It would seem, then, that at least some rudimentary understanding of countertransference by nurses would be desirable in order that patients be treated in a more respectful manner in the hope of obviating the need for continual readmission, a cycle which is beneficial for neither patients nor nurses.

It is the observation of this writer that as staff react to patients less out of their own countertransference feelings, patients are somehow less compelled to act out during their hospital stays. What is not clear is whether the nurses simply get used to the patient and/or whether unrealistic goals for the patient's improvement are relinquished. Perhaps the recognition of countertransference feelings results in a change in the seemingly primitive way the nurse interacts with the patient and the interaction itself evolves to a more complex, meaningful level.

The variables which are related to nurse-patients contacts for providing nursing care include: (a) patient and nurse; (b) social context of the interaction; (c) nature of the interaction; and (d) patient health outcomes (Kim, 1987). It may be that the concept of countertransference can provide information on each of these four variables. Further, the nature of the interaction may be the most important medium through which the nurse can therapeutically influence the patient's health (Kim, 1987). If countertransference is a factor in the nature of the interaction, it can shed some light on how the nurse proceeds in a therapeutic manner. However, it is difficult to assess the utility of the concept of countertransference without first identifying if and how it is understood and experienced by the psychiatric/mental health nurse in practice situations.

Thus, the essential question in this study is "What is it like for a nurse working in the area of psychiatric/mental health nursing to experience feelings of countertransference for a patient?"

Chapter 4

Research Design and Methodology

Data Analysis

The seven steps of Colaizzi's (1978) procedure for phenomenological data analysis were followed. The protocol was read in its entirety, as transcribed verbatim from the audiotaped interview, to gain a sense of the whole. Significant statements which directly pertained to the experience of countertransference were extracted from the protocol. Meanings were formulated as they emerged from the significant statements. These steps were repeated for each protocol. Subsequently, the accumulated formulated meanings (Appendix A) were organized into clusters of themes (Appendix B). The clustered themes were then validated by referring back to the original protocols to see if any data had been added to or ignored. The results of the analysis thus far were integrated into an exhaustive description of the experience of countertransference (Appendix C). The exhaustive description of the phenomenon was then formulated into a statement of identification of its fundamental structure (Appendix D). The analysis was validated by returning to each participant to ascertain whether or not the analysis described their experience.

Sample

The sample consisted of five participants who were interested in articulating their experience of countertransference. The participants were selected according to the following criteria: (a) ability to articulate personal experiences and feelings; (b) ability and willingness to discuss countertransference; (c) demonstrated understanding of the concept of countertransference; (d) active in psychiatric/mental health nursing; and (f) inpatient psychiatric work experience of more than five year's duration. Experienced nurses were sought because they are most likely to be expert practitioners with a deep understanding of total situations, and an ability to focus on the salient features of an experience without being distracted by extraneous variables (Benner, 1984). Participants were solicited through an advertisement in a mental health nurses' interest group newsletter and personal referral.

Two of the participants were male and three were female. Two of the participants were registered psychiatric nurses, and three participants were registered nurses. One participant was studying towards completion of a Master of Nursing degree. One participant had completed a Bachelor of Nursing degree. Three of the participants were involved in study towards a Bachelor of Nursing degree. The least experienced participant had practiced in the area of psychiatric/mental health nursing for 14 years.

The participants' rights were protected in the following ways: (a) the right to participate or withdraw from the study at any time was explained prior to data collection; (b) the participants were given a clear explanation of the purpose of the study and the data collection method; (c) the participants' right to confidentiality was protected by use of code letters and pseudonyms on all written material; (d) an informed consent form was signed by each participant; (e) prior to data collection, the Joint Ethics Review Committee, Faculty of Nursing, University of Alberta approved the study; (f) audiotaped recordings of the interview were transcribed by the investigator thereby ensuring confidentiality; and, (g) the audiotapes, signed consent forms, and code book were stored in a locked cabinet to be kept for seven years. A provision to protect the future rights of the participants is that secondary analysis will not occur without the express written consent of the participants.

All participants were considered to be representative in that sample selection occurred based on the criteria of the participants' knowledge of the experience and the participants' ability to articulate this experience.

Interview Method

Participants were interviewed at a choice of locale. All chose to be interviewed in the investigator's home. Critical skills of the listener which were employed included: (a) being an interested and open listener; (b) putting aside one's personal judgments and preconceptions of the phenomenon in order to focus on the participants' experience; and (c) encouraging participant disclosure and articulation through judicious use of open questions and through reflection and clarification techniques. Verification with the participants that the meaning of the experience had been understood correctly by the investigator necessitated an interview technique which evoked description from the participants without leading the participants or telling them what to say (Knaack, 1984). Participants were encouraged to provide as full a description as possible of their experience of countertransference, which depended upon the investigator's success in formulating the question (Colaizzi, 1978). The question asked of the participants was ""What is it like to care for a patient for whom you are experiencing countertransference?" Other questions were not asked rigidly but matched to the level of personal interaction and mood between the participant and investigator.

Validity and Reliability

Several assumptions form the basis for validity and reliability in phenomenological research (Colaizzi, 1978; Knaack, 1984). Firstly, people are self-observers who pay attention to their thoughts, feelings, and behaviour. The participants had experience with the phenomenon in question, and were able to communicate this experience, thus the data have face and content validity. Secondly, data from each participant were clarified, and checked for accuracy and completeness with the participant throughout the interview. On occasion, the investigator asked leading questions, or attempted to define what the participant was feeling, thereby assuming to know the meaning of the experience for the participant. However, the participants were quick to repudiate false assumptions on the part of the investigator. Therefore, errors in the investigator's communication skill technique did not influence the responses of the participants. Lastly, the investigator collected and analyzed the data. The quality and amount of data were judged to be of sufficient depth to illustrate the participants' subjective experience of the phenomenon as opposed to their theoretical knowledge (Colaizzi, 1978). Thus, only one interview occurred with each participant. The formulated statement of identification of the fundamental structure of the experience of countertransference was returned to each participant for validation. Only one suggestion for an addition was made and this was incorporated into the findings.

Phenomenological reduction or bracketing is the process of bringing to consciousness and setting aside previously conceived beliefs, notions, expectations, and/or hypotheses about what will be discovered in the course of investigating the phenomenon (Colaizzi, 1978; Duffy, 1986; Oiler, 1982; Smith, 1989). This necessarily includes the bracketed assumptions about what will not be discovered. The investigator's bracketed assumptions are included in Appendix E.

Many of the quantitative measures of validity and reliability are not directly applicable to qualitative research. Thus, the criteria of auditability, credibility, and fittingness were used (Guba & Lincoln, 1981).

Auditability can be assured by the process of the researcher leaving a decision trail so that another investigator, having the same perspective and access to the original data, could follow the same steps (Sandelowski, 1986). Biographical information from each participant was collected to provide an audit trail. Appendices A, B, C, and D contain the results of the various steps of data analysis (Colaizzi, 1978).

A study has truth value and is credible if it presents so faithful a description of the lived experience that any reader, having had the same experience, recognizes it as his or her own (Oiler, 1982), or if the reader can recognize the phenomenon in others when it is encountered from just having read about it in the study. Swanson-Kauffman (1986) suggested a review of the interpretation by persons who have experience with the subject matter. An expert psychiatric/mental health nurse first read the original protocols and validated the coding decisions of the investigator. Subsequent to further analysis, this expert nurse reviewed the investigator's interpretation of the data. The investigator herself is an expert psychiatric/mental health nurse which aided in interpreting the data.

The fittingness of a study refers to the application of findings to individual experiences, and, the relationship between the findings and the data. This requirement was partially fulfilled by returning the descriptive identification of the experience of the phenomenon to each participant. Two of the participants suggested the same addition to the collected data upon reading the descriptive identification of the experience. Other than this one addition, the five participants agreed that the description fit with their experience. Fittingness will also be addressed following the completion of the research report. The findings will be shared further with the participants and other interested parties. Thus, the fittingness of the findings is an ongoing process.

Limitations of the Study

It is acknowledged that memory is fallible, and that individuals selectively remember what they have perceived through their own conceptual set (Salsberry, 1989). Further, the experience of the participants is temporal and may change over time. Thus, it is not possible to generalize the findings as being true for even the participants of the study following completion of the study. As such, no claims to the universality of the findings is made. However, it is expected that the findings will provide some level of insight to nurses and will provide challenges and clarifications to the understanding of nurses about the phenomenon of countertransference.

The investigator may have been limited in interpreting and reporting the findings to reflect the full richness and depth of the data. As well, the participants may have been limited in their ability to fully articulate the depth of their experience with the phenomenon.

It is acknowledged that it was unavoidable for the investigator to totally bracket held assumptions and beliefs insofar as these may not have been present in conscious thought, and that by attending to selected aspects of an experience or seeking clarification of a perception, the investigator may have triggered shifts in the meaning a participant assigned to the phenomenon under study (Robinson & Thorne, 1988). The premise that "there is no way to study a thing without changing it" is accepted as an immutable factor in phenomenological design (Sandelowski, 1986, p. 34).

Chapter 5

Findings and Discussion

Findings

The descriptive identification of the countertransference self-awareness structure is presented in its entirety as follows:

> Upon entering the psychiatric practice area, the novice nurse is confronted with the realization that the self is experiencing negative feelings towards patients which are contrary to what the self learned about total objectivity towards patients in nursing school. The novice experiences self-doubt which is perceived to be unique to the self. Thus, the feelings are not openly discussed for fear the self will be judged. Unless a peer provides unsolicited guidance, the novice continues to struggle alone.
>
> The anxiety and self-doubt reach intolerable levels, and the nurse seeks relief by questioning outside the self. An ephiphany occurs when the universality of both positive and negative countertransference is revealed to the self. Concomitantly, the self realizes that the self-imposed requirement of emotional neutrality is not possible, nor is it necessary. That which the self is experiencing is gradually validated as a natural part of the self, and this awakening of self-awareness empowers the self's increasing ability to envision the self's reactions and feelings as present and valid in all interchanges with patients.
>
> As awareness of countertransference phenomena grows, the self recognizes that a self-imposed stance of therapeutic omnipotence is countertransferential in nature and thus, must be abandoned. The self acknowledges that one's hope for the patient may be the antithesis of the patient's hope for himself or herself, and that the patient's wishes must be respected. There is a continual struggle within the self to accept the patient's choices, even if the patient is choosing death. An awareness of and respect for the patient's ability to make such a momentous decision, is founded in the ability of the self to differentiate between what the rational self would

choose and what the rational patient is choosing. The hand-in-hand nature of the growing experience, knowledge, and self-awareness engenders a beginning sense of mastery in the self which is as yet fragile, and which can be undermined by frustration in instances when mastery is reached for but not grasped.

With growing self-awareness, there comes a realization that certain physiological, behavioural, or cognitive clues signal the presence of countertransference. The self becomes more adept at recognizing these clues and is able to bring to consciousness the original identified object which has triggered the countertransference. In situations of positive countertransference, the recognition of the identified object can provide an instantaneous feeling of comfort with the patient. The nurse becomes increasingly able to remove the self intellectually from the countertransferential feelings, assess the source of the transference within the patient, and is thus able to process the symbolic meaning of the patient's behaviour and actions. This enables the nurse to stop the self from reacting to the patient in a way which mirrors the reactions of everyone else in the patient's social surround.

In situations of negative countertransference, an awareness of countertransference enables the nurse to police the self's body language, tone of voice, and processing remarks in order to not transmit negative countertransference to the patient. The nurse is well aware when an attempt to police the self's responses has not been successful. At times, the nurse is aware that the patient has sensed the presence of negative countertransference because the patient has stopped the interaction by verbally withholding, or the patient avoids further interactions with the nurse. However, the self is also increasingly able to judge how to reframe feelings of frustration into appropriate comments which serve to identify the effects of the patient's behaviour on the process of the interaction. The self experiences a sense of mastery when countertransference feelings are controlled and a positive patient outcome is achieved. Conversely, the nurse is increasingly aware of situations in which the self's inability to recognize and effectively deal with the countertransference has put both the self and the patient at risk.

There is a growing awareness that situations, in which the nurturing, concrete, care giving role of the nurse is validated by the patient, are less likely to provoke countertransference. In situations where the patient has a chronic mental illness, countertransference is less likely to be evoked because of the differences in the situational factors of the nurse and the patient. These self-perceived differences preclude strong feelings of identification with the patient and thus, strong countertransference feelings are less likely to occur than in situations where strong feelings of identification with the patient are present. Conversely, negative countertransference can be evoked by the frequent readmission of patients who have chronic mental illnesses because of the seeming inability of the nurse to aid these patients in overcoming the effects of their illnesses and adapting to community life. Thus, these patients fail to validate the care giving role of the nurse by remaining ill.

Feelings of overprotectiveness for the patient signal positive countertransference. An increasing sense of mastery in the nurse allows the incorporation of observations by peers that the nurse is assuming too much responsibility for the patient's welfare and the self is increasingly able to draw back and provide less quantitative, but more appropriate care.

Self-awareness facilitates the ability of the nurse to recognize the presence of countertransference in colleagues. The countertransference of colleagues is interpreted as stemming from several possible roots. Colleagues may be at a less advanced level of self-awareness, and thus more susceptible to the effects of countertransference. There may be discomfort with the aroused feelings which precludes an understanding of countertransference as an important therapeutic tool. However, the increasing sense of self-mastery enables the nurse to provide guidance and support to colleagues in an affirmative manner which allays some of the confusion experienced by colleagues. The nurse is able to draw from the self's own past experience of confusion. The nurse's ability to step back from the affect generated in response to the situation, and subsequently process the dynamics of the situation for others, enhances everyone's understanding of the situation in particular, and of countertransference in general.

Differing role requirements which are predicated by the nurse's encounters with different situations, and which often require rapid shifts in style, can be difficult for the self to accommodate. The self struggles to provide the right attitude at the right time in the right situation, but experiences a sense of resentment at not being able to be fully attentive to the patient and to the self in each situation.

Positive support from colleagues enhances the ability of the nurse to understand the limitations which must be placed on the provision of care in order that a corrective experience is proffered to the patient. The provision of positive support to the nurse, and at times the team, creates an atmosphere in which the self is freed to generate approaches which may not have been previously considered. Conversely, negative support may cause the nurse to isolate the self from the team because of the resentment engendered. The self perceives that one is expected to deal with unacceptable feelings about the patient without help.

The continuing struggle within the self to acknowledge and understand countertransference is exemplified by the struggle to accept the remarks of others, whether they occur informally in passing or whether they are part of formal supervision. In situations where negative support is indirect and takes the form of negative remarks about the patient, the nurse may assume the judgment of others by a process of guilt by association. This is in part engendered by the self's own feelings of inadequacy about one's seeming inability to help the patient progress. The nurse experiences regret that a more direct form of questioning did not occur, as this may have served to enhance the ability of the self to understand how the negative countertransference interfered with the relationship between the patient and the nurse.

Alternately, formal supervision is experienced as negative when it inhibits the nurse's sense of direction in what to explore with the patient. The nurse recognizes that without leadership, the self cannot progress beyond the limitations of the self in interactions with patients, and thus determines that the best course is to err on the side of safety for the patient in not exploring what is beyond the self-perceived ability of the nurse to process.

At times, the nurse outwardly appears to ignore negative remarks. However, the nurse may cognitively weigh the relative truth value of the remarks and self-question in relation to them. With a growing self-awareness, there occurs recognition that all remarks, whether they be direct or indirect, positive or negative, provide a touchstone for the self in bringing into consciousness that which may, as yet, be unconscious.

The nurse comes to realize that no matter how much supervision and support is offered, the self is alone with the self in interactions with patients. The comments and interpretations of others overlay the process of the interaction between the nurse and the patient in that they provide a viewpoint which must be evaluated against what is now being experienced. In addition, the nurse must process the self's emotional reactions to what the patient is saying and interpret the meaning embedded in the words. The management of this triad of forces requires an exquisite level of ability within the nurse.

The nurse who has a developed understanding about countertransference, and who has incorporated this into practice, is aware of the need to oscillate the level of attachment between the self and the patient in order that the self may draw back when necessary, and be drawn in when it is called for. The nurse understands that a desire to self-disclose to the patient may or may not be driven by the self's unconscious needs. The self works to assess the appropriateness of the self-disclosure from the view of what the patient needs before making the decision. The nurse becomes more able to judge the difference between when countertransference is present, and when the self is experiencing an ordinary reaction that anyone might have when faced with similar patient behaviour.

In situations where the negative countertransference is of such strength as to negate the possibility of self-monitoring, the nurse has the self-confidence to ask a colleague to assume care. In situations where self-monitoring alerts the nurse that the self is experiencing or has experienced issues similar to what the patient is experiencing, self-policing takes the form of attempting not to impose what the self needs onto the interaction. When the self recognizes that empathy is present, the self is able to skillfully guide the interaction in such a way that the patient need not spend so much time trying to make himself or herself understood, and thus, the therapeutic relationship is opened up.

> In situations of positive countertransference, self-monitoring takes the form of knowing when the self is assuming too much responsibility for the patient, or recognizing when the self, because of strong feelings of identification with the patient's situation, has predetermined the course of the therapy in a way which precludes the patient's unique experience and wishes. The self also assesses what the patient is asking for and what it is reasonable to give, even if this is sometimes contrary to the wishes of the nurse. Alternately, the nurse may deliberately assume a great deal of responsibility for the patient, give more than is strictly necessary, and not experience regret because the result was a positive outcome for the patient.
>
> The nurse comes to appreciate the complexity of countertransference and experiences lingering regret for past interactions which might have had a better outcome, had the nurse been more aware of what the self and the patient brought to the interaction. However, there is a poignant recognition that the development of self-awareness had to unfold as it did, that self-awareness does not come without pain, and that the growth of self-awareness is an infinite process. To think anything else would be to acknowledge that one had not learned anything at all.

These findings will be discussed as they emerged from the data, as they relate to the reviewed literature, and from the investigator's perspective. The discussion of the findings was organized in accordance with the clustered formulated meanings of the subjective experience. The implications for research, education, and/or practice will occur at the end of each section as relevant.

Findings and Discussion

Arousal of self-doubt in the novice nurse.

The lived experience of countertransference reveals itself to be a process of the growth of self-awareness in the nurse which is initiated in novices by the presence of self-doubt. The participants recalled experiencing feelings of guilt and inadequacy when they were novices, and identified the feelings as stemming from a realization that the stance of total objectivity taught in nursing school was difficult to adhere to in practice. Eden recalled a growing awareness that it was impossible to be totally objective:

> I thought you had to be totally objective. Because, after all, you didn't know this person, right? They were a stranger, you were a stranger to them, and therefore, like other kinds of nursing, you should be able to carry out your...duties. It doesn't work that way.

The recalled feelings of inadequacy in the novice were further compounded by a fear that the self was unique in being unable to deal unemotionally with patients especially, as Eden points out, since other nurses had no seeming difficulties with the same patients:

> I didn't like it to happen because I wanted to be able to be therapeutic with anyone that I was to care for. I guess I felt like how come somebody else can deal with this person and I can't and therefore must be somewhat inadequate. That's how it made me feel.

The identified feelings of inadequacy prevented any open expression to colleagues of negative feelings toward the patient with the attendant fear that the novice would be judged by others as inadequate as well. Barbara recalls "I didn't ever feel that I could talk to anybody about the feelings that I had...about the patient because I didn't want to be judged as having really bad feelings about the patient."

The recalled experience of the initial struggle of the novice was an unexpected finding. The reviewed literature does not provide any illumination on this point. Thus, this serendipitous finding sheds light on a part of the experience not previously discussed. The finding has implications for nurse educators and administrators, as well as more experienced nurses who may be able to aid novices in beginning to process what they are experiencing upon entering the psychiatric practice area. Qualitative research which explores the experiences of novices in psychiatric/mental health areas may delineate their experiences more fully.

Universality as a turning point in self-awareness.

It is when the participants recognized that others too, were experiencing similar feelings, and that emotional neutrality was neither possible nor necessary, that a turning point in the growth of self-awareness was reached. Carlos was able to recall a period of time in which he reached a turning point, and how he became able to understand that what he was experiencing was commonplace:

> I think a lot of that realization came around the time I was dealing with that fellow the stockbroker. And I was also reading a book on psychodynamic psychotherapy around the same time too and it talked a lot about that

> and I think the two...I just came to realize that yes, any therapist is human and has whatever issues, and there probably would be no therapists if you had to be perfect or all your issues resolved before you could be a therapist. So I think the two sort of just came hand in hand. I think really sought out some readings around the same time because I was struggling with that so I think it was a combination of experiencing it in the sessions with this fellow and reading something about it.

The realization of the universality of the experience of positive and negative countertransference as a turning point for the participants was an unexpected finding. The reviewed literature does not provide any information about this experience. That a turning point occurred long after a time when the participants could still be considered novices, and that this step was largely initiated by an experienced need to understand more, has implications for nursing as a whole. Role prescription for what to do when a nurse dislikes a patient is virtually absent from the educational and clinical literature (Hall & Mitsunaga, 1979). The described process of accepting universality and understanding that emotional neutrality is not necessary adds to the knowledge about how countertransference comes to be understood. Further research is needed to explain how nurses who do not embrace this concept process their feelings for patients and how these nurses make sense of difficult clinical situations.

Therapeutic omnipotence and the interactional nature of countertransference.

The phenomenon of therapeutic omnipotence is well-described in the literature (Dunkel & Hatfield, 1986; Kernberg, 1965; Main, 1957; Mark, 1980; Sharaf & Levinson, 1964). It is generally seen as mechanism in which the patient makes a conscious or unconscious plea for help which is responded to by a nurse who may feel special due to being the recipient of the plea (Main, 1957). However, an omnipotent response is different than authentic concern for the patient because mature concern has to include reality and it is often quite impossible for the nurse to totally help the patient (Kernberg, 1965). In fact, the provision of constant warmth and nurturing for all patients at all times, rather than an empathic accepting response within reasonable limits, may provide a milieu in which patients regress further (Mark, 1980).

The findings reveal that the participants came to terms with their own experienced therapeutic omnipotence by understanding it as a manifestation of countertransference. Amber's experience illuminates how difficult it can be to let go of therapeutic omnipotence:

> And so, she was simply waiting for that part to go. And she wasn't going to do anything to help it. I think there was an awareness that, that was what was happening. ...that there was very much a hope on my part that we could change that. But I think after we did the interviews and I saw her literally say "I love

> you and goodbye" to her daughters, I think I then began to realize "this is Eve's choice. This is what she is doing". It was almost...there was a very conscious to me, yet passive communication that "I am not prepared to do anything else but leave this world". So, I don't remember grappling with feelings of hopelessness. Because, there was simply an acceptance that Eve as a fully functional, dignified...at least once fully functional, dignified woman, had now reached a point where life didn't have any joy for her and she wanted to go. And I may have been in denial...I don't know...but I don't remember feeling frustrated that she wouldn't respond more than she did. I remember...I think I had glimmers of it. She'd tease me every once in a while and I would think "Oh, we're getting somewhere" and then the light would go off or the door would close again. And I began to realize that...this seemed to be all that she was capable of.

The importance of this vignette lies in its illustration of a patient choosing death over life. This can be a difficult issue for nurses. The ability of Amber to overcome her own need to help the patient, and to redefine what help means in this case, is remarkable.

A sense of freedom is encountered when the nurse is able to wrestle free from the extreme responsibility of feeling therapeutically omnipotent, and thus totally responsible for solving the patient's problems. Derek's statement best illustrates this:

> I think that I operated under the idea that I was a therapist so I was supposed to make a difference, and the difference was sort of the dramatic shift from not healthy to healthy. And that I, as a therapist, was supposed to bring that all about. And if I didn't know what I was doing the whole time and if I wasn't going towards that, then I was doing something wrong.... I still feel good about the resolution of the work with her because all the work around countertransference and that sort of thing helped me recognize that the impact I was going to make in this situation was limited in the sense that I wasn't going to change those things,

> that she had had for a long time and I wasn't going to make a major impression on that in a short period of time. So through that I was able to change my expectations of what I was going to do as a therapist in that situation.

Although Rogers (1970) might argue that the role of the nurse is to be present with the patient throughout the course of the problem, this is often not possible due to a number of factors in the psychiatric/mental health practice area. Often the patient has numerous problems of long standing which cannot all be relieved within the context of inpatient treatment. Thus, the nurse is placed in the position of deciding what it is that can be reasonably achieved. An understanding about the countertransferential nature of therapeutic omnipotence aided the participants in making this decision.

The participants were clear in articulating that in their experience, countertransference gradually came to be understood as existing within the interaction between patient and nurse. In fact, it is the contextual nature of the relationship which actuates its presence. The experience of the participants is consistent with the opinions of Heimann (1950) and Little (1951) who agreed that countertransference is interactional in nature, and Kernberg (1965) who viewed countertransference as a natural and expected emotional response elicited in the context of the relationship of the patient. Barbara advanced the idea that even if the phenomenon were not called countertransference, it would have to be identified in some way, in order that the nurse could begin to process the emotions generated by a therapeutic interaction:

> And I don't think you have to follow any specific psychodynamically oriented or any other...I mean you could call it anything else...if it wasn't countertransference...it's there, it happens. When the nurse and the patient are there together, you've got that relationship where two people are evolving as the relationship goes, I mean, we can say that patients have transference, we know that we can stir something in a patient, and I think the same can happen to us.

The identification of the effect of the nurse on the patient, and conversely the patient on the nurse, ties this facet of countertransference to Rogers' (1970) idea that the nurse and the patient are part of each other's environmental energy fields. Life is seen as an evolutionary emergent (Rogers, 1970); therefore, both the patient and the nurse evolve by virtue of interacting with each other. Barbara identified the facet of two human systems in interaction with each other. Carlos provides support for Barbara's impressions:

> I think it's an interaction. There's a constant interaction between the patient and the nurse and that they can sort of either inhibit each other or feed on each other...sort of suppress each other or escalate what's going on.

However, Carlos' perception depicts another facet of the interaction in his described awareness of the ability of either the nurse or the patient to determine the course of the interaction by acting and reacting.

The participants' growing knowledge and experiences, which nourish an understanding of their role in the interaction, encouraged them to begin the struggle to gain some mastery over the self, as Eden's statements attest:

> There's a lot of personal investment, there's a lot of agonizing, and trying to get over, are you a good nurse, are you a good therapist, how do I get to be one, all of those questions. And so you have to go through in your head what you did, what you didn't do, could you have done this or that better, is there going to be a next time to prove that. For me that's really big because I want to be good.

Eden also identifies the recognition that this growth is a slow process and that the experiential side of it must necessarily occur:

> It's a learning process. It doesn't happen quickly. And I don't think it should because I think if it did, you wouldn't learn what you needed to. I think you have to go through all kinds of experiences with all kinds of people.

Although the nurse is gaining a sense of self-mastery with the recognition of the futility of therapeutic omnipotence, and the acceptance of countertransference as present in interactions with patients, there is frustration that Derek identifies when the feelings are still encountered:

> In some ways, learning about countertransference enhanced that idea because it's like, the more you know about something and the more it occurs, there's that tendency to become more frustrated when it does happen as opposed to seeing it as part of a natural process.

This described sense of frustration points out that the participants wished to achieve mastery over the self quickly, and were surprised when it did not occur, despite their growing understanding of countertransference.

The admission of self-awareness of therapeutic omnipotence and subsequently, the ability of the nurse to process it and find a personally acceptable compromise, was a serendipitous finding. The investigator did not expect that the participants would identify this aspect of countertransference. Research which examines the experience of therapeutic omnipotence within other subspeciality areas in nursing may shed light on whether this is a widely experienced feeling within nursing, or whether it is unique to psychiatric/mental health nurses.

The finding that countertransference was recognized by the participants as being interactional in nature fit with the bracketed assumption that countertransference is a normal reaction encountered daily in psychiatric/mental health settings. Where the findings went beyond this bracketed assumption was in the participants' depth of understanding about the effects patient and nurse could have on each other. The notion of life as an evolutionary emergent (Rogers, 1970), was supported by the findings which implied that the participants had a subjective understanding of Rogers' environmental field concepts.

The participants' described awareness that they needed the experience of working with differing patients in differing situations in order to accumulate gains in self-awareness, supports Benner's (1984) idea that clinical knowledge is gained over time. The frustration encountered by the participants when countertransference continued to be experienced was an unexpected finding. Research which examines the countertransference experience at various stages of the nurse's development is needed in order to delineate where this finding fits in the overall scheme of the development of clinical expertise.

The self attending to clues within the self.

The participants describe that an awareness of countertransference within the self can be signalled by a variety of clues. The clues vary from person to person and from situation to situation, but include the physiological signal which Barbara identifies:

> I looked for a physiological cue, and I had a feeling in the pit of my stomach, and I knew that if I have that, that something was wrong.

Another signal can be identified when the nurse is reluctant to work with a patient:

> ...a violent patient. It was really...part of that is the fight or flight response. But another part of it was my fear toward this patient, my response was that this patient was going to destroy me or harm me or hurt me in some way. So I got so I didn't want to...if that patient was violent, I didn't want to work with them because I feared them.

Barbara discriminates between countertransference and fear; two emotions aroused by the situation of caring for patients who have been violent. This finding ties the participants' experience to the opinion of Katz and Kirkland (1990) who observed that nurses experience countertransference toward patients who have assaulted them, and that these countertransferential feelings contribute to the nurse's subsequent avoidance of the patient.

The nurse becomes adept at recognizing that certain types of patient are especially able to evoke a countertransference response. Carlos' past experiences have taught him which patients he is susceptible to and how he knows that he is susceptible: "The intense feeling towards somebody, for whatever reason, and classically it's the borderline patient or individuals with personality disorders."

The participants were able to describe their ability to identify the occurrence of either negative or positive countertransference for a patient. Derek's experiences reflect how the nurse comes to a quick recognition that either is occurring:

> I think that's come with a combination of experience and knowledge but I think that there's several ways that I recognize that it's happening. If I walk in and have an immediate reaction of any kind to a patient, my first guess now is that there's countertransference going on.

Further, the participants described countertransference as occurring in an initial reaction to a patient, or within the context of ongoing interactions. Derek adds a dimension when he describes a cognitive clue to the presence of countertransference which is triggered by recognition of a certain behaviour in himself:

> I think if it happens with a patient that I don't know anything about, that's clues, but I think it's ongoing too...if, for example, I find myself trying too hard...to effect the course that therapy takes, and that's sort of an ongoing process with somebody that you know or have known for a while. I think that's a clue too. So I think it's both, I think it's initial reactions and I think it's also ongoing reactions too.

The participants portrayed an ability to recognize the object from their own lives which provided the identification with the patient. This identification was present in situations of both negative and positive countertransference. For example, Amber describes a situation in which she experienced strong positive countertransference for a patient who reminded her of an elderly cousin:

> And there was everything about the way she sat in her chair, about her profile, there was everything about her that reminded me very, very much of a woman who had been close to me all my life. And this particular woman was a second cousin and she would have at that time probably been close to 80. A bit older than this particular patient. But nonetheless, there was the physical similarities, slightly permed grey-white hair, about the same size, the soft white, never-in-the-sun skin, and also a similar history of a long marriage, abruptly ended and that extraordinary sense of loss that she felt as a result of it.... So when I saw her sitting there, I think the sun was sort of coming in the room and she was just sitting, just totally still, in a chair, a bit in a profile and I looked at her and I thought "Oh my god, it's Elizabeth". And I just had a tremendous feeling of--I think I know this person. I felt very comfortable with her almost as if, I sort of felt like I could sit down and start to have a

> conversation with her in a way that was impossible with a lot of other patients because I felt almost as if I knew something about her. There was something between the lines that I felt I knew, which of course had everything to do with Elizabeth and nothing to do with this particular patient, for sure.

Amber fully recognizes that although the patient reminds her of someone she knows very well, Amber does not, as yet, have any knowledge about this particular patient.

The participants were also able to identify that when their own issues were close to what the patient was experiencing, providing a therapeutic interaction to the patient became more difficult. Carlos describes this as a boundary issue between patient and nurse:

> I think the hardest ones are the ones where, for one reason or another, the issues...where I've identified strongly with that individual and most of the time it's been sort of close age and close circumstances to a certain extent.... And the more blurred those boundaries get, the more difficult it is. And I think the closer the circumstances, the more you share the same issues or similar issues with the individual you're working with, the more blurred it gets and the more difficult it makes it.

Eden's ideas about identification add another dimension to the experience because, as she points out, each nurse has an individual set of experiences and values which contribute to the uniqueness of the experience of countertransference:

> To me it's always been a case of who they remind you of or people that you think that you would like. And I think each of us have our own idea of who that is or what characteristics about them that is.

The participants identified that an awareness of countertransference in themselves led them to begin to try and determine what the patient's role was in provoking it. Although this was not discussed in great length or depth, it alludes to the participant's awareness that the patient has some role to play in the genesis of countertransference. The reviewed literature indicates that the patient's role in countertransference is predicated by the mechanism of projective identification (Heimann, 1950; Klein, 1946; Little, 1951; Racker, 1957; Winnicott, 1949). The participants described their ability to identify the patient's behaviour, their ability to understand what role the behaviour served in perpetuating the patient's pathology, and their ability to step back from the patient and stop reacting in ways similar to everyone else in the patient's social surround. Although the mechanism of projective identification was not directly described by the participants, the implication of the findings is that these participants were able to process the experience of projective identification without naming it. Derek provides a vignette which illustrates the process through which he is able to step beyond the countertransference generated by the patient's anxiety state:

> I think that once I was able to understand the countertransference part, I think it gave me a lot more information of how she perceived things, how she reacted to things, a lot of her, sort of the underlying things that were going on her. But when I was more in the countertransference thing, I wasn't able to see those things. Like I wasn't able to separate and say "well maybe she's doing this because of such and such"

> or "maybe this is her response to certain things that happen" or "maybe it's her only way of coping" or whatever, to look at any of those other alternatives. So once I was able to do that, and I think also able to use the countertransference in the therapeutic sense in that, if she does this to me, or if I have this reaction to what she's doing or saying or whatever, chances are other people in her life or in her environment are doing the same thing, and perpetuating the whole system and keeping her where she is with her anxiety. And that...I suppose, what I'm saying is that it helped me to understand more how her anxiety was useful and adaptive for her.

Therefore, the nurse attends to feelings generated by countertransference, and learns to move beyond these in interpreting the symbolic meaning behind the patient's behaviour, as Derek describes. This finding supported the view of Hagey (1984) who suggested that the interpretation of dramatic narrative must be preserved in nursing for problem identification.

The nurse learns to control the self's body language so that negative countertransference is not so readily transmitted to the patient. Eden describes a vignette in which she mitigates the possible effects of her negative countertransference by both the use of nonrejecting body language and appropriate confrontation:

> I generally start to turn it around and to...you know, what did you do at that moment, and what did you say, and try and put it in the you, and try and get them back into what their role was in any kind of an action. That's very hard but you have to be very persistent, that's what I believe. Not in an abrupt manner. The timing has to be right. Has to be a bit of a trust built up obviously. It's not so much what you're saying, it's how you're saying it too. The tone of your voice, how you're looking, are you going to sit there and take the time. People know when you want to

> get away quickly, if you've written them off. That's a really important action.

The participants' experience demonstrates an ability to control the expression of feelings, even if the feelings themselves cannot be controlled. McMahon (1992) was of the opinion that discrepancies between nurses' overt communication and their inner feelings derived from failure to recognize and incorporate countertransference. This view is supported by Eden's observation that she knows the patient knows when Eden has negative countertransference and is transmitting it.

The continued growth of self-awareness is fueled by a growing sense of self-mastery which enables the participants to effect positive patient outcomes. Barbara fully describes an interaction with a patient in which her self-mastery provided for a positive patient outcome:

> And an example of appropriate confrontation is that I guess what I've learned to do is disagree without being so disagreeable with a patient. For example, a patient who is diagnosed with borderline personality disorder...if I'm setting limits, I try to watch the tone of my voice, and I try to say something to the effect, like an example that I have with one patient is that she wanted to go off the unit and smoke cigarettes and she was scheduled for an ECT treatment. And I said...no...it's more, it's...how did I put it? "I would like you to stay on the unit." And I explained why she should stay and not have a cigarette prior to ECT. And she started to really shout and scream at me on the desk, and I just said, in a very calm tone of voice, that I understood that she was angry, that she wasn't getting what she wanted right now but that we could talk about this later and right now, she needed to go and prepare herself for the treatment. She eventually accepted that whereas I think that if I had have said "Well you shouldn't be smoking" or something

> like that, and it would have escalated her, and we would have had some knock-down, drag-out, kind of mud-slinging session. She would have ended up feeling...most likely feeling really upset by it and maybe would have done something to sabotage the ECT. That was my thinking.

In this case, Barbara's self-mastery also provided a positive outcome for herself, and the other staff, in that a potentially violent episode was defused. Carlos describes a contrasting situation in which both the patient and Carlos were put in an unsafe situation because Carlos became overinvolved in trying to process the interaction which precluded his ability to take control of the situation:

> It almost seemed like...I was trying to see how much I could control him. It was like, how much I could work with him. I trying to think now, what it was that was agitating him, because the lady wasn't in the room, she was outside somewhere else, and I think what I was trying to do was...he wanted to see her, and I kept saying no, she doesn't want to see you. It was sort of that interaction, almost back and forth. And it almost like, I wanted to see how much I could calm him down and make him understand this. Me, myself, you know, and realistically, in retrospect, it wasn't realistic, I mean he, because of the relationship and all that was going on between them and him, but it was sort of like how much can I do this. So I think...I was doing it as much for me as I was for him.

Role validation is a theme which emerged from the data in that participants were aware this played a part in whether countertransference was evoked or not. Strictly care giving roles were perceived as less likely to evoke countertransference because there was less personal investment and less sense of identification with the patient, as Carlos describes:

> It's sort of getting back to working with the chronically mentally ill. Rightly or wrongly, in some ways they're easy to work with because a lot of the time, particularly when they're very ill, you're not focussing...you're not really focussing on some of those more personal or sensitive issues...you're focussing more on psychotic symptoms which I find more safe or, you know, there's not the same sort of personal identification with them or whatever.... I think the thing about with a psychodynamic approach, you are more involved in a sense than in other approaches like...well obviously with medication, it's not as much of an issue, but even sort of behavioural approach, it's more mechanical and that you're able...there's very much more a stepping back and telling people what to do, you know, try this or that, whereas in a more psychodynamic approach it's more intensive connecting with the individual and exploring things with them and sort of...more of an interaction and it's a more intense experience in a lot of ways than some other approaches such as behavioural.

May and Kelly (1982) have suggested that role validation for the nurse occurs when the patient by word, deed, or condition, legitimates the nurses' therapeutic aspirations and that where this applies, the patient is likely to be viewed positively. This suggestion is of some value in explaining Carlos' experience in that the role of the nurse in providing instrumental care to severely ill patients is fairly circumscribed. However, as Eden described "I have seen a lot of negative countertransference towards chronically mentally ill patients who have repeated admissions to psychiatric units. Again, why can't we fix them?" This part of the countertransference experience is consistent with the reviewed literature and has been described as arising from the view that chronically mentally ill patients exhibit poor improvement and have a poor prognosis, thus evoking feelings of helplessness and hopelessness in their caregivers (Book, Sadavoy, & Silver, 1978; Colson, et al., 1985).

In contrast to the self-mastery needed to effectively process negative countertransference in the self, the participants indicated that positive countertransference requires an equal, but opposite degree of diligence. The struggle within the nurse to provide objective care in the face of positive countertransference is best exemplified by Amber's experience:

> With the particular patient that I'm thinking of, for whom I had positive countertransference, the overwhelming feeling was responsibility. I've cared for people for whom I had negative countertransference and I suppose for a time the overwhelming feeling was frustration, but in this one, recognizing that my feelings were extremely positive and extremely empathetic, I was really concerned about going too far the other way, and I felt a tremendous responsibility to try and be empathetic and use that to the best possible way with the patient but yet at the same time, try and remain objective.

The growth of self-awareness was described as enabling the ability of the participants to receive feedback from others as to the limits their care should take, and thus the effects of overprotectiveness were mitigated. Eden describes her ability to process the remarks of others in this regard:

> It's those patients that maybe I put hours and hours and hours into, tried everything, and hoped and hoped that something would work, have run out of ideas and so has everybody else on the team, and so, yeah, we've probably gone more than the extra mile, and we're

> frustrated. I'm frustrated anyway. Again, we can talk about it. We need one person in the group to say, that's it, we can't do anymore.

These findings enhance the knowledge about the countertransference experience. Particularly, the findings support a view that self analysis helps nurses not to cure but to learn cues, and helps nurses resolve more and learn skills to further self-observe (Searles, 1979).

It was assumed by the investigator that countertransference is an unconscious process which gradually comes into awareness, sometimes long after the provocative event. Therefore, the finding that nurses learn to attend to a wide variety of clues which can signal the presence of countertransference was a serendipitous finding. The ability of the participants to recognize countertransference as occurring before meeting a patient, upon meeting a patient, and within the context of an ongoing interaction, points to their ability to transcend their unconscious reactions and quickly bring them into consciousness. Thus, the finding adds knowledge to the debate about the conscious or unconscious nature of countertransference. An alternate view of this finding is that the participants were experiencing simple reactions and did not differentiate between reaction and countertransference. Research is needed which seeks to discover whether nurses have an understanding of the differences between the two, or whether they consider differentiating between reaction and countertransference to be an academic exercise. It may be that, in practice, the differentiation is arbitrary and that the clues which signal either reaction or countertransference are processed in similar ways.

The participants did not name the mechanism of projective identification. This omission was in opposition to the bracketed assumptions of the investigator. Research which seeks to uncover whether this mechanism is understood by nurses working in psychiatric/mental health practice areas is needed. There is a suggestion that nurses who cannot make use of objective countertransference data are involved in projective counter-identification (Grinberg, 1962). The nurse, without being aware of it, experiences the self as portrayed in the patient's projective identifications and is unable to prevent the self from being what the patient unconsciously wants the nurse to be (Grinberg, 1962; Kernberg, 1965).

However, it may be that identification of projective identification is an academic exercise because as Sandler (1987) pointed out, the delineation about which part of the countertransference comes from the patient, and which part comes from the nurse, is likely to remain as a difficult technical problem. The participants' experience implied that they understood that patients require the nurses' ability to tolerate both the nurses' and the patients' deep feelings (Winnicott, 1949), no matter where the genesis of the feelings is. Further, the participants' described experiences implied that they had a well-developed ability to process the meanings embedded in the patient's words and behaviours, and this implication may indicate that the step of recognizing projective identification can be bypassed.

That a theoretical knowledge of psychodynamics is imperative to the nurse working in the psychiatric/mental health area was a bracketed assumption of the investigator. The participants' ability to recognize the mechanism of identification and differentiate the identified object from the original source of the identification, as well as an ability to recognize and mitigate the effects of identification on the interaction, supports the investigator's view.

Self-mastery as an enabling factor in the provision of support to colleagues.

The participants described situations in which they noted the countertransference responses of others, and had some guesses as to why the countertransference was occurring. Barbara notes that the other members of the team are at a preliminary stage of awareness about countertransference:

> It's interesting to note that in working with this patient, that sometimes when I work with the physician,

> I don't feel like she's at that level with that understanding either. I see a lot of staff around me as sort of panic stricken and sort of at the same level I was years ago with that initial patient who self-mutilated in that they wanted to protect the patient, felt responsible, got really angry.

Derek interprets the lack of awareness in his peers about countertransference as confusion, which interferes with understanding:

> In the work situation right now, I think...sort of spoken and unspoken, I think there's a lot of confusion and a lot of fear about countertransference, and so I think people make jokes about it, people laugh about it, people will say "well, this is my own issues coming in here" laughing, in a joking way, but I don't know that it's ever really talked about, and ever really understood as a real...what I've come to believe, as a real therapeutic tool, and a real important therapeutic tool. So I think...my guess is that there's still a lot of fear around it and that it's still seen as a very negative, scary thing. And I wish that weren't so in some senses because I think that if people were more aware about it and understood it more, and understood how it comes into play, I think that would make a real difference in the way things are done.

The ability of the participants to monitor the other members of the team supports the view that an awareness of countertransference is of potential value for all clinicians in monitoring both their reactions to patients, and the reactions of others (Sandler, Holder, and Dare, 1970).

The participants were also able to identify instances wherein they provided guidance to other nurses in a manner which made the observations and processing well received. Barbara outlines one such situation in which the processing of the countertransference included interpreting the meaning behind the patient's behaviour:

> So what I did this time is I looked at that patient who was mutilating herself...instead of feeling responsible for her I thought, she's responsible for herself. I didn't feel angry. But I thought to myself, when this other staff are talking about how angry they feel with her, I thought, maybe this is the patient saying...and they were responding in angry ways, and I was thinking, maybe she's angry with us, maybe she's angry with somebody identified in her...other therapists who she has worked with in the past. And maybe she's...working this out with us. I think once we discussed this, and I was able to discuss it with the staff, I think we learned a lot more about the patient.

The participants' described ability to step back from the affect generated in response to the situation, and subsequently process the dynamics of the situation for others, was perceived to enhance everyone's understanding of the situation in particular, and of countertransference in general. The finding implies that without self-awareness and an achieved comfort level within that self-awareness, the participants would not have been able to help others. The investigator assumed that nurses need to feel secure in discussing self-perceived socially and professionally unacceptable feelings. It was not expected that the participants' attained sense of security would enable them to assist others in processing countertransference. Thus, questions about the necessity of developing leaders who can help others in this regard are raised.

Differing role requirements.

Differing role requirements which are predicated by the nurse's encounters with different situations, and which often require rapid shifts in style, were identified as a factor interfering with the participants' ability to attend to patients in a way that was satisfactory to the nurses. This finding supports an opinion that the roles of psychotherapist and pharmacotherapist (Bradley, 1990), as well as behaviour manager, are difficult to juggle in the face of rapid transition from one patient to the next, all of whom have different needs. Barbara's comments illustrate the frustrations encountered in this situation:

> I think it's unrealistic to expect that nurses can step into any situation and be totally objective all the time. I mean we don't demand that of very many people and in an acute inpatient unit, it's very difficult because you're slipping from one model to the next. You're giving medications, you're running around after the doctor, you're trying to do intensive psychotherapy with a patient in one corner, and then you have to get up and walk to the next room, and you're doing custodial care to a psychogeriatric patients who's cognitively impaired and you know, you're asked to slip in and out of these things and so there's that whole issue, you know, the countertransference issue...it's almost...it's really hard to sit down in the middle of the day and say well I feel this, this, and this about the patient because you've encountered six different patients during the course of the day and you're having to slip in and out of that all the time.

The identified feelings of resentment stemmed from the participants' inability to attend to countertransference when it was occurring. Although Weigert (1954) was discussing the analytic situation, he pointed out that there was a certain tension between the ideal of empathy and its realization in daily professional performances. The implication of this finding, then, is that these nurses were aware of the tension and could describe feelings aroused by it.

Different treatment settings were identified as requiring differing boundaries on the role of the nurse, as Carlos describes:

> My perception or my thought right now is that it's more difficult, some of those issues are more difficult in an out-patient setting because again, sometimes the people are more stable, have fewer symptoms or whatever, and the other thing is the environment isn't as structured. Sometimes you're doing home visits, and going and seeing them on their turf and that, and I think that's important to see people on their own setting and understand that. But also, you have to step out of the role because you're having tea with them or whatever, or you're walking into their house and meeting their family. I think it's more difficult, at times anyway, to keep the relationship clearer because you don't want it to be such a rigid therapeutic relationship that they just perceive it as that. But still you want to keep some...make the roles clear.

The social context of an inpatient unit as a factor in limiting or encouraging the expression of countertransferential material was a bracketed assumption of the investigator. For the participants, role confusion was frequently present and the participants were left alone to deal with this confusion. This finding has implications for the development needs of nurses who are struggling within an area of practice, or for nurses who move to different practice settings, and thus, become novices again.

Support from colleagues as a facilitator of continued growth of self-awareness.

Positive support can be a self-growth enhancing experience for the nurse, as Amber describes:

> And I remember one of the psychiatrists saying to me "Yes, what we fear the most is doing patient's harm." And I can remember getting tears in my eyes at that time because I thought, he understands, I'm really quite afraid of stepping over some sort of mark here. So I did, I kept in contact with the team, and particularly with those two psychiatrists to really talk about my feelings and sort things through and it was a real balancing act for me.

As well, positive support may allow the team to work cohesively within differing role assignments and generate creative approaches to dealing with difficult situations, as Eden articulates:

> There was one time, I remember, we had a number, a number of these patients on our unit. We had the fortune of working with a psychiatrist who really valued them a lot.... Kind of believed in the firm approach for one staff with the reward of having the brief conversation with another staff, or possibly him, frequently, and so that the behaviours would have to be such that they would earn that reward. That really turned it around for me a lot because I realized it was possible, something could work. However, it happened--the mutilations, the out-of-control, everything like that. As a group we had to hang on to, what could we do to make the best of the situation. We worked as a team, we wrote up a wonderful standard care plan...we felt really challenged and so we turned it into a positive. ...prior to that though, I was very frustrated, didn't really know what to do. You need direction. You really do. This person provided the direction to all of us.

The benefits of direct supervision by viewing were also considered important to the growth of self-awareness because another may be able to see what the nurse cannot. Carlos describes this situation as follows:

> That's one of the benefits of, if there is an opportunity to have someone viewing, because sometimes those can be very subtle things that you're not aware of, sort of directing conversation in a different direction, even the way you follow up on information that you're given or the questions you ask can obviously be influenced by your own comfortability [sic] or sensitivity or whatever, to certain topics or issues.

However, the supervision experience may be perceived as negative. Any suggestion that negative countertransference is occurring may trigger feelings of defensiveness in the nurse, or the nurse may not respect the abilities of the supervisor, and therefore feel inhibited in what can be explored. Carlos' vignette highlights this facet of the supervision experience:

> I wasn't comfortable with the supervision I was getting and feeling like I was out of my element and didn't have the backup and so I just backed away from that. To explore those sort of things, I know I have to feel comfortable with whoever I'm working with, whoever's supervising me, to really sort of open up and feel like I'm really getting something, not just getting patronized or you know, lectured to or whatever the particular situation is.

Negative support was described as precipitating two scenarios. Firstly, where negative support took the form of indirect remarks about the patient or the nurse, the nurse withdrew from the team in order to not invoke further judgment. Derek provides a description of this scenario:

> And I think in the context of jokes and in the way it was presented, it again adds to that defensiveness

> about it, and I think, perhaps in some senses with me, it encouraged me to be more isolated in terms of what I was doing and not tell people or not talk to people or not get feedback from people necessarily that I could have gotten. ...it was mostly...directed towards the patient, in terms of she should be out of here or she's been here long enough. Or sometimes, just offhand remarks about...I can't remember any of them directly but remarks that implied that maybe you were too involved or maybe you weren't seeing it clearly or maybe you weren't...maybe you were sucked in by something she was saying or something. So it was never a direct comment or even a direct question about, what are your feelings towards her, or is there anything that you've experienced that might be getting in the way of your relationship with this woman, or whatever. So I think that the indirectness of it lends to sort of that confusion about what you're doing, or whether you're doing the right thing, or...like the guilt.

Secondly, although the negative support was outwardly ignored, the participants experienced times when they were able to incorporate the comments into an evaluation of whether or not they were experiencing negative countertransference. Again, Derek outlines this scenario:

> It made me question myself in terms of...and maybe in that sense, it was good questioning because even though I would say something to put it off or change the subject or whatever, it did encourage me to think about, is this really going on. But, I think part of that was because I was more experienced. Had I been less experienced that might have been a real deterrent to learning more about it or might have...just enhanced a real feeling of inadequacy in terms of what I do as a therapist.

Although the treatment team is discussed in the reviewed literature in terms of responses to splitting (Kernberg, 1965), and in terms of the advantages and disadvantages of processing countertransference in team meetings, there was no discovered indication of the effects of negative or positive support on the individual nurse. The depth and breadth of the participants' described experiences and feelings was therefore, a serendipitous finding.

This finding, in its entirety, raises important implications for practice, and in particular, implications about the role of the team in encouraging or discouraging the expression of negative countertransference in the individual nurse. Several authors have recommended the use of team meetings to process countertransference feelings (Brobyn, Goren, & Lego, 1987; Di Bella, 1979; Gallop, 1985; Maier, 1986; Piccinino, 1990; Witherspoon, 1985) with the provision that these meetings be safe for nurses in order to encourage openness and honesty in disclosure of feelings about patients (Johnson & Silver, 1988). However, it must be recognized that simply identifying countertransference reactions does not necessarily lead to resolve (Schroder, 1985). Thus, team meetings which purport to deal with countertransference must be skillfully handled, and this raises questions related to the development needs of individuals who may be required to facilitate these meetings.

The struggle within a state of aloneness.

The experience of the participants was clear in identifying that self-awareness and mastery of self are necessary in order that nurses provide corrective experiences to the patient, or in other words, the nurse's relative success in not providing the patient with the same reactions that everyone else in the patient's life provides. Derek's vignette best identifies the state of aloneness experienced in trying to manage that which the patient brings to the interaction, that which the nurse brings, and that which has been suggested by others:

> It wasn't helpful in the sense that it still left me, I mean it was good to talk to him about it and get some ideas about it, but it still left me alone with me in the session. And so I had to sort of wing my way through, trying to remember what he said, trying to focus on what we were talking about at the time, and trying to be aware of my own feelings too. So, it was still a bit difficult in that sense, but better.

While there was considerable discussion about that which the nurse and patient bring to the interaction, there was no indication in the reviewed literature about the effects of an overlaying set of interpretations on the interaction.

The situation Derek mentions has also been called "the acrobatic act on the tightrope" by Amber, who, in relating her experience with a patient, exemplifies the level of self-awareness needed to avoid imposing the self's attachment needs onto the patient:

> I knew that she had problems with good-bye. I'm not sure that I was altogether prepared for her to say unequivocally, good-bye, and yet it was exactly what I had hoped...I mean, when you think about grief work, people have to choose their way to do it. She chose this way and it was almost like I was saying if you'd only done it another way maybe you'd feel better today and yet it came up to the point when the two of us were having to say good-bye, and here I was thinking "Oh my god, do I want her to say good-bye? Is she ready to say good-bye?" And I thought, get a grip here kid, this is what you want her to be able to say. You want her to feel safe enough and comfortable enough and to know that the person she's saying good-bye to won't be devastated by this. And then thought what a remarkable...it was almost like a tribute...that she could just straighten her back and look directly into my eyes and say "Good-bye Amber". And I thought...thumb in the air! I don't think I was fully prepared that she was going to write me off at that time, I think it did come as a surprise.... And I think that's why I had this, the acrobatic act on the tightrope thinking "good god, I wasn't expecting this," I was expecting her to say..."Oh yes, and could you make it every Tuesday" or whatever...that was unrealistic. And I wasn't even prepared to get into a long term follow-up commitment with her if it could be helped because I wasn't too sure what more we could do. But yet when it did come, it was a surprise, and so then I thought, well, when she showed that anger, that's when I thought "Okay, this is another good-bye, she's angry with me, fair enough...but am I just going to leave this here or am I going to say, is this what it is"...and that's when I thought," can I handle this? What does it mean if I do? What does it mean if I don't?" And there was simply too much to lose for me not to confront it and not to be able to handle it. Because she really needed, I think...well maybe she didn't need it...but I really needed for her to need me to be together and for her to just say it honestly and I would not be devastated.

Thus, Amber, who has been drawn into caring for Eve, must now draw back from Eve as Eve requires. Amber is able to oscillate her level of attachment to Eve according to what Eve needs, not what Amber needs.

The decision whether or not to self-disclose was identified as a part of countertransference which also requires the ability of the nurse to weigh whose needs would be met if it occurred. Self-disclosure can be confusing to both nurse and patient, as Carlos outlines:

> At times I would self-disclose but I think it's very tricky...well you have to be extra careful in that sort of situation because I'm sure it would be confusing for the other person as well, it would get even more blurred as to who was trying to help who. So I'd have to...again I'd really have to think about it, but I was very careful in okay, what's being discussed here, and whose issues were whose.

However, at times, self-disclosure is determined to be necessary to allay patient confusion. Eden discusses a situation in which a patient may have misinterpreted Eden's reaction to something the patient said, had Eden not clarified the situation:

> I just remember this other patient who reminded me so much of my sister. We'd have long, long talks. She was very cynical, quite a funny, dry sense of humour. And she would say a few things that...in the middle of therapy I can remember starting to laugh and the poor woman...it wasn't a funny issue. And I had to explain what was going on. She was actually flattered by it and I think that was an important part of acknowledging what happened to the patient. We proceeded really well from there. She even had the same voice tone. It was amazing. And so I needed to explain that. Like I said, our relationship was kept very professional, but I think she needed to have the truth, and we were fine from there.

The participants' awareness of self-disclosure as a part of countertransference phenomena was an unexpected finding.

A growth of self-awareness was described as enhancing the ability of the participants to differentiate between that which is a simple reaction that anyone might experience when confronted with a similar situation, and that which is countertransference arising from the self's own issues. Barbara's experience provides insight into this awareness:

> I think it's hard for us to understand that we have to act as role models for patients in ways which require us to do some self-exploration. And I feel like that's sort of a key in the whole countertransference issue because there are certain things that...happen within us. It may be as a result of something which happened in the past but there are also things that we have to respond to because we are humans. And I think that countertransference, for me, I look at it now as something that has those two features. That it's possible that something can be activated within me as a result of some past experience that I've had but it can also be like just an ordinary type of response to some kind of patient remark or activity.

Self-awareness was identified as including the dimension of transferring care when the participants experienced negative countertransference to such an extent that they did not think it could be overcome. The decision to transfer care, then, may be based on the nurse's desire to provide care which is not harmful, and requires self-growth which has reached the level of forgiveness for imperfections in the self, as Carlos describes:

> I believe that you need to be aware of your issues and when they surface in therapy, and either be able to put them aside at the time and deal with them at another time, or at least not let them interfere with the contact you're having with the patient, the individual, or if you're not able to do that, to be able to say that, to whoever, and say that "no, for such and such a

> reason I can no longer see this person because of whatever".

This finding is contrasted with the opinion of Holden (1990a) who interpreted a nurse's withdrawal from a patient as negating the possibility of a self-growth experience. However, it is difficult to understand this author's views when one considers that firstly, the nurse in this situation is aware of negative countertransference which cannot be overcome, and secondly, a nurse in this situation may not be able to obtain guidance in how to proceed.

A high degree of self-awareness was described as a necessary factor in determining when, because of the nurse's similar experience with a patient's issues, the needs of the nurse might be interfering with the patient's work. In Carlos' experience of this situation, awareness of countertransference allowed him to recognize when he might be imposing his own need for resolution onto the patient:

> I think when I found I was particularly conscious of blurred boundaries or whatever, or my own issues sort of surfacing, I was much more careful on being clear on what I was saying or what was being focussed on in the session, to try and make sure that it was in fact issues he was identifying, and not ones I was trying to sort of superimpose on the session or what have you.

This finding supports the view of Venn and Derdeyn (1988) who pointed out that the strength of the reaction of countertransference is mitigated by the manner in which staffs' past needs and conflicts influence their reactions to the clinical situation.

Derek's experience with issues similar to those a patient has, shows another side of this experience:

> One that comes to mind is working with a young guy who was brought up in a very strict, religious family which is the same that I was brought up in. And I think that it's been a positive experience in the sense that I understand a lot of what he's operating with and dealing with, because I experienced the same thing. And experienced, probably a lot of the same dilemmas that he's experiencing now, in terms of wanting to individuate a bit from that religious background, but having a lot of trouble with it because it's not what he's supposed to do. And it doesn't fit in with how his whole family sees that he should be doing things and his own sort of morals and values right now. So I can think of many instances with him where it's been a positive thing in that I was able to...I think able to more quickly understand his perspective because I had experienced the same perspective and the same sort of feelings that he had around all that. I think it's really helpful because it sort of cuts down the amount of time that I have to spend really trying to understand their perspective.

Thus, the nurse is able to use that part of countertransference which is empathy to open up the therapeutic relationship. Empathy, as one form of countertransference, has been called concordant identification by Racker (1957) and is differentiated from sympathy, which is a form of negative countertransference (Holden, 1990a). Inherent is the requirement that the nurse, despite experiencing empathy, not predetermine the course of therapy by invalidating the patient's unique experience and wishes for resolution, as Derek describes.

> I think that it would be easy to get into, either deciding on a certain course of treatment and saying that's that how it goes...it has to go, and if it

> doesn't go that way, then it's their fault, they're non-compliant or resistive, or whatever.

This finding ties the experience of the participants to Weigert's (1954) observation that in order to evaluate the information gained from empathy, the analyst had the imperative to be aware of the danger of the subjectivity involved in the process of identification, particularly as it related to any form of prejudice on the part of the analyst.

Mastery of the self was found to include management of positive countertransference. The participants identified their recognition of situations in which they were assuming too much responsibility for the patient. However, the participants agreed that there were certain situations in which they thought and felt it appropriate to be overinvolved. The overinvolvement occurred with full recognition of the positive countertransference, as Eden describes:

> The patients I remember, being overinvolved with, often resemble members of my family where I have been known to be overinvolved because I'm the nurse in the family. For example, there recently was a cute eighty-year-old couple who came into our hospital and really didn't need to. She had given up their nursing home beds because she was angry and it was like, around Christmas time. So I thought, oh my god, what are we going to do. So anyway, we...myself, I certainly talked to the psychiatrist who happened to catch this cute little old couple and we admitted them over Christmas. They were together over Christmas. That was so important to me. They reminded me of my parents, obviously, this is what I'm getting at, who are also in their eighties, and a couple that I'm trying to make sure they're comfortable, wherever their home is at any given stage

> in their retirement. And I certainly went to great lengths to try and make sure this couple was placed in the same lodge, in the same room. I spent a lot of time on that when, in fact, interestingly enough, this lady was very capable of doing a lot for herself, and she just loved me, obviously, glommed right on to me. I don't obviously have a lot of regrets. They had their last Christmas together. And, although I was overinvolved, I felt good about it.

This described experience exemplifies the suggestion that fear of countertransference should not lead to the suppression of all human freedom in reactions to patients (Fenichel, 1939).

This group of experiences supports an assumption that a high degree of self-awareness and ego strength in the nurse, as a result of having resolved some of his or her own issues, contributes to the ability of the nurse to provide therapeutic interventions to patients. The finding supports Kim's (1987) view that an understanding of the nature of the nurse-patient interaction will enhance and improve the delivery of nursing therapies. Where research is needed is in measuring the effects of the nurse's therapies on the dependent variable of patient health outcomes.

The ability of the participants to differentiate between self-disclosure which stems from countertransference and that which does not, was an unexpected finding, and thus adds to the knowledge base in this area. The finding suggests a need for further research which examines the basis from which decisions to self-disclose are made in all areas of nursing.

Infinity and the growth of self-awareness.

The respondents identified that an awareness of the complexity of countertransference phenomena included regret for past interactions, which might have had better outcomes for the patient were the nurse better able to process the countertransference. Barbara's descriptor exemplifies a situation, long past, in which negative countertransference was not mitigated:

> I think that my response told me that he probably did feel some guilt. You know, and I also think that both of our responses were inappropriate...both the patient's and mine, and if we had of been in a position where we were able to talk about it a little bit more, he might have worked it through, and he may have died feeling less guilty.

However, these difficult past situations were seen by the participants to be a necessary part of their learning experience, as Barbara describes:

> There have been times when I've looked at and I have known that maybe I could have said it someway differently but that's part of your learning process as a nurse is that you learn and unfortunately patients have to be your example...your teacher, and you're the pupil and you get better.

There is also what Derek describes as a sense of the need to be continuously evolving:

> But I think that...where I am now is an evolution from then even, and even though that was an improvement over what I initially had, I think it's an evolutionary process all the time. Constantly...I don't think you ever get to the point where you're perfectly aware and know how to use it...I think there's always times when you walk out of a room saying "well, I shouldn't have said that" or "I missed there" or whatever.

Finally, Eden provides a statement which sums up the infinite nature of the growth of self-awareness:

> I don't think we're ever done. We don't know what's around the corner. Who we're going to encounter, what they might do or say, and what reactions it's going to cause in us. It would be foolish to think that we are done. In fact, that would mean that we hadn't learned a lot at all.

Conclusion

The lived experience of countertransference is revealed as a process of the continuous growth of self-awareness. Initially, the experience entails the struggle to abandon objectivity, emotional neutrality, and therapeutic omnipotence. It is the abandonment of these principles which enables the nurse to begin to use the self's experienced emotions therapeutically in interactions with patients.

For the participants, the feelings aroused in the self came to be understood as having meaning within the concept of countertransference and thus, came to be understood as a normal, human response to caring. It is the continuing ability of these nurses to transcend this normal, human response, and to use their growing self-awareness to provide an appropriate level of care to the patient, that is the hallmark of the lived experience.

In closing, Schopenhauer's parable may be most apt in describing what it is to provide care so that neither nurse nor patient falls victim to the effects of caring too little or too much.

> A number of porcupines huddled together for warmth on a cold day in winter; but, as they began to prick one another with their quills, they were obliged to disperse. However the cold drove them together again, when just the same thing happened. At last, after many turns of huddling and dispersing, they discovered that they would be best off by remaining at a little distance from one another.
>
> Schopenhauer, (1981, p. 226)

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Appendix A

Formulated Meanings

1. The novice nurse is confronted with feelings about patients that confuse the self. The help provided to the novice in this initial awareness determines how quickly and successfully the self begins to gain some understanding about the concept of countertransference and how it relates to what the self is experiencing.

2. Initially, the nurse does not know why the tenet of total objectivity in the provision of nursing care cannot be adhered to. Negative feelings toward the patient confuse the nurse and as the feelings are struggled with, help may be sought from outside the self to make some sense of the feelings.

3. Recognition that others are experiencing the same feelings, and to such an extent that countertransference phenomena are described in textbooks and articles, the nurse realizes that the self is not alone in experiencing these feelings. This can result in a turning point in which the nurse begins to incorporate an understanding of countertransference into the way the self processes interactions with patients.

4. The nurse recognizes feelings of therapeutic omnipotence within the self and begins to come to grips with the futility of this stance.

5. There is a reluctance in the nurse to discuss negative countertransference openly for several reasons which include the belief that one is a bad nurse or therapist for experiencing negative feelings toward the patient, guilt, inadequacy, and fear of evoking the judgment of others if the countertransference is revealed.

6. The existence of countertransference feelings for a patient gradually come to be understood to exist within the context of the interaction between patient and nurse.

7. The nurse experiences lingering regret for past interactions which may have had a more positive outcome for the patient had the nurse been more able to recognize countertransference in the self and deal with this feeling before responding to the patient.

8. For a nurse who has experience and self-knowledge about countertransference, there is a recognition that encounters with certain types of situations, certain illnesses or disorders, and certain types of patients, are likely to provoke countertransference. This recognition comes into the conscious awareness of the nurse by means of cognition of physiological clues. The recognition of countertransference can occur prior to meeting the patient, on initial meeting, or within the context of the interaction.

9. The nurse who is aware of the concept of countertransference and who has incorporated this awareness, knows that the self is particularly vulnerable to countertransference in cases wherein some kind of negative or positive identification with the patient or the patient's victim has been induced.

10. With a greater understanding of countertransference, there occurs an awareness in the self that the experience of countertransference may be communicating something about the patient.

11. The hand-in-hand nature of experience, knowledge, and self-awareness works to increase the nurse's understanding of countertransference at it occurs in the self, to increase the ability to process countertransference within the self, and to experience of satisfaction in gaining some mastery over the self. However, this may result in frustration with the self when the countertransference continues to be experienced.

12. An awareness of countertransference in the self leads to an awareness that other members of the treatment team are experiencing it in ways which may or may not mirror the ways in which the self is experiencing countertransference.

13. There is an acknowledgement by the nurse that factors in the work place can inhibit the processing of feelings of countertransference.

14. Countertransference occurs in situations with chronically ill, psychiatric patients but is easier for the self to process than with those patients who are on the more personality disordered end of the spectrum. This is due to the nature of the relationship with patients with chronic mental illnesses in that there occurs more of a caregiver to patient relationship in which the tasks are instrumental and the interventions directive, as these tend to challenge the unconscious processes of the nurse somewhat less than more intensive interactions. Conversely, negative countertransference can be evoked by the frequent readmission of patients with chronic mental illness.

15. Strong feelings of wishing to control patients with whom one is irritated are easier to control in the self because the feelings are more overt and the behaviour in the patient is considered to be more overtly inappropriate. This is in opposition to countertransferential feelings in a psychotherapy session which may be more subtle and less easy to determine as to their genesis.

16. The nurse constantly oscillates from gauging what it is the patient needs and gauging what it is the self needs. Responses and interventions are offered from this perspective. The struggle to respond to the dynamics and the process of the interaction rather than to the content is the hallmark of the incorporation of the knowledge of the ever present countertransference without and within the nurse.

17. The recognition and acceptance of countertransference as a normal part of the self which is evoked in interactions with patients, is a process of becoming and a process of giving and taking. But, because it is a process, there is no finite end, rather there is the continued struggle to understand what parts of the self are insinuating themselves into the therapeutic interaction and when the reactions of the nurse are not based in feelings of countertransference.

18. A recognition that positive countertransference is occurring is understood by the nurse to require an equal degree of diligence in the self as does recognition that negative countertransference is occurring. The overwhelming feeling is one of responsibility for the patient which carries an attendant need to constantly be aware when too much responsibility for the patient is being offered.

19. Once conceptually aware of countertransference, and once it has been accepted as a normal part of the patient-nurse interaction, the nurse works to bring these largely unconscious feelings into consciousness. This may result in interactions where a positive outcome has been achieved.

20. An awareness of negative countertransference may result in the nurse asking someone else to take over the care of the patient if the countertransference is not able to be overcome and the nurse feels that continuing may be detrimental to the patient.

21. Support is garnered from any available quarter, whether it be nurses, or other colleagues such as physicians or psychologists. This may take the form of direct supervision by viewing, or supervision by discussing the case with an interested other, and results in a decision about a direction to be taken. Support which is perceived as positive by the nurse enhances the confidence with which the self continues to work with the patient.

22. Perceived negative comments or non-supportive attitudes from colleagues about the presence of countertransference in the nurse can be destructive in that they cause defensiveness because of the implication that the nurse is doing something wrong, or is a bad therapist. This may result in the nurse's reluctance to ask for help and may block the ability of the nurse to understand how countertransference is blocking a satisfactory intervention with the patient.

23. Support which is perceived as negative by the nurse raises the anxiety of the nurse which may be responded to in the form of seeking help either from self-analysis, readings, direct supervision, or discussion of the case with an interested other. This leads to the growth of self-awareness in the nurse.

24. The nurse identifies negatively or positively with the patient but through a growing awareness of countertransference, recognizes the differences between the original object which provides the identification, and the patient, who is unique. This precludes a premature decision as to the direction the nursing interaction will take.

25. No matter how much supervision and support is provided from others in the matter of countertransference, the nurse must rely on the self during the course of the interaction.

26. Overinvolvement with the patient's pathological processes is recognized by the nurse to be dangerous to both patient and nurse in that both are put at risk by the countertransference of the nurse who, in becoming so fascinated with the process of the patient's thinking, cannot take control of the situation for the mutual safety of the patient and the nurse.

27. Negative countertransference is recognized by the nurse to lead to non-therapeutic interventions such as abruptness or anger. These types of responses are acknowledged as providing a barrier to further therapeutic interventions. The patient may sense that the nurse is experiencing negative countertransference feelings for the patient and respond by withdrawing or choosing not to disclose to that particular nurse.

28. With a growing awareness of countertransference in the self, the nurse is increasingly able to recognize the occurrence of countertransference in others and may, at times, help others process these countertransference feelings.

29. The decision whether or not to self-disclose to a patient is a recognized part of processing countertransference feelings.

30. Nurses who are aware of the effects of positive countertransference, are aware when they are becoming overinvolved with patients and they consciously determine the extent to which they will go in the provision of care.

31. The nurse comes to understand that the experience of countertransference is an evolutionary process which requires the constant attention of the self.

Appendix B

Clustered Meanings

1. The novice nurse is initially confused by the presence of strong feelings that are in opposition to what the self is taught about total objectivity in the provision of care. The novice nurse is thus reluctant to discuss these feelings and senses that the self may be bad or inadequate for experiencing these feelings.

2. The nurse begins to understand the universality of the experience of countertransference and a turning point is reached.

3. A growing awareness of countertransference leads the nurse to abandon the self-imposed stance of therapeutic omnipotence, to recognize that the feelings exist within the interaction between the self and the patient, and to experience an increasing ability to process countertransference within the self. However, frustration within the self occurs when countertransference continues to occur.

4. There is an ongoing effort to recognize countertransference when it occurs, to bring into consciousness the unconscious feelings which are aroused by some physiological or cognitive clue, to assess what the presence of countertransference may be saying about the patient's interactional patterns, and to incorporate this growing awareness of countertransference into interactions with patients. Recognition of positive countertransference dictates an equal degree of diligence in the self as does recognition of negative countertransference in that there must be vigilance in determining when too much responsibility for the patient is being offered.

5. There is a growing ability to recognize the manifestations of countertransference in others which, depending upon the nurse's own comfort with countertransference, can lead to helping others process their feelings in constructive ways.

6. There is a recognition that the self's ability to process countertransference can be influenced by factors in the workplace.

7. Support, whether negative or positive, may result in a growth of self-awareness. Positive support enhances the possibility of generating positive outcomes for patient and nurse. Negative support may be processed in two ways. Either the nurse isolates the self from the other members of the team to avoid further comments which can inhibit the work with the patient or the nurse's anxiety is raised sufficiently that the self seeks positive help in order to make sense of what is being experienced.

8. There is a recognition that no matter how much help and support are sought and offered, the self is alone in interactions with patients. There is a constant struggle within the self to assess the interventions from the basis of what the patient needs rather than what the self needs. What the patient needs may include transferring care to another nurse, avoiding premature decisions about the course therapy will take, and especially with positive countertransference, determining whether the self is going too far in providing care to the patient.

9. With a full appreciation of the concept of countertransference, there is regret for past interactions which went badly because of self-perceived deficits in knowledge and understanding about countertransference. However, the nurse also realizes that the growth of self-awareness has no finite end.

Appendix C

Exhaustive Description of the Experience of Countertransference

When I first began nursing in psychiatry, I was a novice nurse. I had been taught that I should be objective to all patients and not judge anyone. I naively believed this. Therefore, when I found myself having strong negative feelings towards patients, I found it very upsetting. I was upset when I saw other nurses dealing with patients in a neutral way, when I myself had been abrupt with the same patients. This made me feel inadequate and like I was a bad nurse. I could not bring myself to talk to anyone about it because I felt that they too, would think I was a bad nurse. Luckily, there were other people around me who noticed that I was having trouble and helped me to understand some of the things that I was experiencing.

What I was taught about countertransference in nursing school could not possibly have prepared me for the experience of it. I did not understand the full implications of countertransference until I was placed in drastic situations and needed to understand more about what was going on. Sometimes psychiatrists, who knew a lot about countertransference, helped me by pointing out kindly that what I was experiencing was countertransference, and sometimes I read books about it. The theory I read helped me to understand what I was experiencing. I began to realize that almost everyone who is involved in doing therapy with patients experiences these feelings. This was a turning point for me. I realized that every therapist or nurse had issues they brought to therapy and that it was unrealistic of me to think that I had to be perfect - perfect in not having any strong feelings for a patient and not having any strong reactions to what the patient was doing. I had an epiphany when I realized that there was a name for what I was experiencing and there was a way that my new knowledge could help me to deal with these feelings in myself so that I could do better work with patients.

I began to see countertransference as a part of every relationship I had with a patient. Whether I liked the person or did not like them, I knew it was always there. As I gained more experience with more kinds of people, I noticed that I had more ability to notice countertransference in myself and I was more willing to look at myself. My self-awareness was growing but I also know that I had always had some self-awareness, and that I always had intuition about what people were feeling and how to act towards them. I think this might have helped my understanding of countertransference and my willingness to learn more about it. But sometimes, I would get angry with myself when I was still experiencing countertransference because I thought I should know better by now.

I began to realize that there was a limit to how much I could help people. I found out that people will only go as far in therapy as they want to or are able to, and that there are blocks to their ability to get well which are beyond my control. I also found out that I could not change everything about a person when I had a limited time to work with them and that working on just a piece of the problem was all right. I also discovered that I sometimes had unrealistic expectations about a patient that came from my denial about how sick this person really was. I did not want to believe that there was a limit to how much they could possibly get better. Even with Eve who had decided that she didn't want to live after the death of her husband, I gradually came to realize that this was her choice, that she was competent to make it, and that I had to step back and not try to get her to make a different choice.

I began to notice that I knew I had countertransference when I would immediately think that I did not want to work with somebody before even meeting them or after a hard day with them. I also knew I had it when I would get this feeling in the pit of my stomach when the patient said or did something. I began to realize that there were certain situations or types of patients that would provoke almost instant countertransference feelings in me. If the patient had done something to somebody who reminded me of someone in my family, I would be angry with the patient. If the patient reminded me of someone I liked very much, I would feel warm and kind towards the patient. Sometimes I had the uncanny sense that I knew this person without really talking to them. And sometimes the patient was close to me in age and some of my own personal circumstances, or had the same kinds of problems I did with my family and I would have a hard time staying objective in therapy.

I began to see that when I was experiencing countertransference, it was possible that this was telling me something about the patient. It could be that the patient provoked these same feelings in everyone around him or her and that there was a sort of stability for the patient in this. It might be that if I was experiencing guilt about a patient's condition, the patient was experiencing it too. When I was able to see that my feelings might be telling me something about the patient, I began to be able to step back and not react the way everyone else was to this patient.

I also knew that I had not dealt with my countertransference when I was abrupt with a patient which sometimes resulted in the patient avoiding me or when I made an inappropriate response which the patient did not respond to. When I knew I was having negative countertransference, I did things to counteract it like watching my tone of voice, attending to the patient, confronting in more appropriate ways and at more appropriate times during the course of therapy sessions.

I felt disappointed when patients who I had done a lot of work with came back into hospital with the same problems. However, I began to realize that patients have good periods and bad periods, just like anyone else.

In a situation where I am providing more custodial type care, where patient and staff safety is a concern, and even if I am angry at a patient, I can process this quickly and deal with situations competently. I know I am angry at a patient because their behaviour is really inappropriate or even dangerous and I find that when I feel a strong urge to control a patient, I can recognize this and deal with it quickly because it is so overt. I am also more comfortable when I am working with the more chronically mentally ill where the boundaries of what I need to do while providing care are clear. The things I need to do are mostly instrumental and I do not have to get the patient to examine anything in their life. I also know that I feel more comfortable because I do not have any sense of personal identification with the patient, or there's more distance between their situation and mine, somehow. It is also more comfortable for me to be in a nurturing role because it is familiar to me and less complicated than doing therapy. However, I do experience frustration when the same chronically ill patients come into hospital again and again and I think this is because we are so unsuccessful in treating them.

I have, on occasion, become so fascinated with how a patient was acting that I put both myself and the patient at risk because I could not draw back and control the situation. I did not realize that my processing of what the patient was going through was inappropriate to the situation.

I am aware that strong liking for a patient can result in me feeling an overwhelming sense of responsibility for the patient and sometimes, a feeling of overprotectiveness. Sometimes I need someone I respect to help me understand the boundaries I need to put on how much care I will give. And sometimes I need someone I respect to say, stop, that is all we can do.

It is harder for me to understand my feelings toward a patient when I am in a more psychotherapeutic situation with him or her. I know this is partially because the situation itself is more intense. There is not much guidance on how to go but I do know that I have to stay with the intensity because that is how the patient gets helped.

I feel good when I understand my countertransference and I am able to help patients understand some of the behaviour they are exhibiting which is not getting the results they want. In fact, it usually gets them the opposite of what they want by driving others away instead of attracting them. I also feel good when I can stay rational in a situation which results in a less explosive outcome than if I had acted out of my own countertransference and showed irritation or controlling behaviours to the patient.

Sometimes I am the only person in the team who feels a particular way about a patient. I can be the only person experiencing positive feelings for the patient, or I can see others at a less advanced level of understanding than I am at about the countertransference the patient is provoking. I also see other people on the team struggling with their confusion about countertransference and I see that they are not yet at the point where they see countertransference as a useful therapeutic tool. I have also been in situations where the patient, myself, and some members of the team, all have similar issues and this makes it very hard to help the patient as there is no one who can take that step back and identify what is going on. As well, I have been in situations where the patient is so skilled at splitting that even though a fairly experienced team can identify that splitting is going on, there is a lack of power to stop it because the individual team members cannot see how they are being effected, they can only see how the splitting is effecting their co-workers.

I have, at times, talked with other members of the team about countertransference and, particular, what it might be telling us about what the patient is experiencing or working through with us. I have found through doing this, that other people are usually receptive to my input because they want to understand how to move on.

Sometimes I do not have time to process what I am feeling because of the multiple demands on my time. And sometimes I cannot process my feelings because of the number of different roles I must take on in providing care. I have to be custodial, nurturing, controlling, and then therapeutic all in rapid succession and sometimes the shifts in style are hard to make. Also, in working in outpatients, I have been aware that my role is expanded and that I have to set the boundaries more carefully and by myself, because in those situations, I am going out to patients' homes and meeting their families and this requires me to be more careful with the boundaries I place on my care.

Positive support is very helpful to me. Sometimes someone has acknowledged that they know how afraid I am of doing harm to a patient with my care and this has touched me and helped me to carry on. Sometimes positive support has helped the team to decide on a treatment approach which would not have been possible without support and permission of some sort, and probably would not have even been thought of. Even an approach which was fairly instrumental changed my views about what could be done for the patient and this was helpful because it gave me confidence in my ability to provide care to patients I had previously found difficult to deal with.

Negative support was unhelpful to me in that I felt resentful that I was expected to deal with all these bad feelings without help. Sometimes when I admitted my feelings publicly, I felt put down and judged by the comments of others and this stopped me from wanting to express any more feelings. It was hard to hear indirect negative remarks from other people about the patient, and probably indirectly about me, because if the comments or questions had been more direct in questioning me about my feelings, I could have understood how these feelings might be getting in the way of the relationship between the patient and myself.

I do know that even when I was supervised, I sometimes reacted defensively because I felt that what I was doing was bad or wrong and that inhibited me in what I might say to a patient or what I might explore with them. If I did not feel comfortable with the people who were supervising me, I knew it stopped me at a certain point in the therapy with a patient because I felt uncomfortable in going farther without support. I did not even feel it was ethical or safe for me to go into areas where I felt uncomfortable without good leadership.

Sometimes when people were making negative comments, I would change the subject. But because I was more experienced by then, I might think to myself, is this really going on. And sometimes my awareness of countertransference made me able to discuss it openly with others who were pointing out my own countertransference, and I was able to talk about what I was doing with the patient and why I was doing it instead of feeling inadequate and defensive. I find it helps to have both negative and positive remarks about your work with a patient because it gives you a basis from which to compare either set of remarks and maybe gives you a sense of balance about what you are doing.

No matter how much help and support were given to me by other people, when I was in an interaction with a patient, I knew I was alone with my own feelings. How I handled things was my decision alone. Sometimes this meant I had to keep the suggestions another person had made in the back of my mind and process these along with my own feelings. This was difficult, but better than if no suggestions had been made.

I knew that I always had to overcome what I was feeling about what the patient wanted, or how the patient had to go through it, particularly if it was not what I would have chosen for the patient. I have been able to stop myself from being angry at a patient by stepping back and saying to myself, the patient has choices too, and that I must respect or at least allow those choices and not feel responsible for them. I will also, if I consider it to be appropriate, check out what the patient is saying and what it means with the patient. As the patient and I feel more comfortable with each other, this is easier and easier to do. Sometimes I self-disclosed with the full knowledge that this was a very tricky thing to do in terms of where, in my own countertransference, the need to self-disclose was coming from. But I knew the difference between when I was correctly judging that self-disclosure on my part was necessary to allay the confusion of the patient as to how I was reacting, and when I knew it would only add to the confusion of the patient.

Sometimes I feel uncomfortable in interactions with patients because my issues are so similar to theirs' that I feel I have no right to try and help this person when I have not worked out my own issues. These feelings made me realize when I was probably projecting my own unresolved issues onto the patient's situation, and when my concern about my issues was distracting me from the patient's issues. But these feelings also allowed me to be aware enough to step back and differentiate between what the patient's experience with his or her issue was, and what my experience with my issue was. At times, this stopped me from superimposing my own issues on the session.

When my negative countertransference is too overwhelming, I feel I should be able to ask someone else to take over care of the patient because I know that I will not be able to work it through sufficiently to be of any help to the patient.

When I have positive countertransference, I am careful to acknowledge the differences between the experience I am identifying with, and the patient's experience, which is unique. I am careful not to impose my own experience on the patient in such a way that it obscures the differences between what I wanted for an outcome in a particular situation and what the patient wants for an outcome in a similar situation. I know that I have to be careful not to determine ahead of time what the outcome of the therapy will be. However, when I have similar experiences to the patient, it helps me achieve empathy more quickly and the patient does not have to do so much explaining. This empathy opens up the therapeutic interaction more quickly and fully. As well, when I feel I have a special understanding about some of the patient's circumstances, I sometimes use behaviours and a manner of speaking with the patient which mirrors my experience with the original source of that special understanding. I think my comfort level which the interaction style I have chosen and which comes from the past experience, is transmitted to the patient, and I have had very good responses from the patient to these.

Sometimes I have been aware that I was overinvolved and I was even fully aware of the reasons behind the positive countertransference. I have gone beyond the call of duty for a patient and have felt good about it. I think I know the difference between when this is appropriate and when taking too much responsibility is doing the patient harm.

As I gain more and more understanding about countertransference, I can look back at situations with patients that went badly and I now know what I could have done differently. I feel regretful that I did not handle those situations better. At the same time, I also know that doing things badly is part of the learning experience and that I had to go through these bad experiences to get to where I am now.

I now know the difference between the kind of countertransference that comes from my past issues and the kind of countertransference that comes from something the patient says or does. I also know not to blame either myself or the patient and instead, process the feeling at a higher level and use it to understand the meaning behind the interaction. I also know when my reactions to patients are not countertransference, but ordinary reactions that anyone might have when faced with the same behaviour.

Despite the knowledge and self-awareness I have now compared to when I started nursing, I know that I can never be finished, because I will continue to evolve from this point just as I have evolved to here from my starting point. As I understand the nature of the growth of self-awareness, thinking you are fully self-aware tells you that you still have not learned anything at all.

Appendix D

Descriptive Identification of Countertransference Self-Awareness Structure

Upon entering the psychiatric practice area, the novice nurse is confronted with the realization that the self is experiencing negative feelings towards patients which are contrary to what the self learned about total objectivity towards patients in nursing school. The novice experiences self-doubt which is perceived to be unique to the self. Thus, the feelings are not openly discussed for fear the self will be judged. Unless a peer provides unsolicited guidance, the novice continues to struggle alone.

The anxiety and self-doubt reach intolerable levels, and the nurse seeks relief by questioning outside the self. An ephiphany occurs when the universality of both positive and negative countertransference is revealed to the self. Concomitantly, the self realizes that the self-imposed requirement of emotional neutrality is not possible, nor is it necessary. That which the self is experiencing is gradually validated as a natural part of the self and this awakening of self-awareness empowers the self's increasing ability to envision the self's reactions and feelings as present and valid in all interchanges with patients.

As awareness of countertransference phenomena grows, the self recognizes that a self-imposed stance of therapeutic omnipotence is countertransferential in nature and thus, must be abandoned. The self acknowledges that one's hope for the patient may be the antithesis of the patient's hope for himself or herself and that the patient's wishes must be respected. There is a continual struggle within the self to accept the patient's choices, even if the patient is choosing death. An awareness of and respect for the patient's ability to make such a momentous decision is founded in the ability of the self to differentiate between what the rational self would choose and what the rational patient is choosing. The hand-in-hand nature of the growing experience, knowledge, and self-awareness engenders a beginning sense of mastery in the self which is as yet fragile, and which can be undermined by frustration in instances when mastery is reached for but not grasped.

With growing self-awareness, there comes a realization that certain physiological, behavioural, or cognitive clues signal the presence of countertransference. The self becomes more adept at recognizing these clues and is able to bring to consciousness the original identified object which has triggered the countertransference. In situations of positive countertransference, the recognition of the identified object can provide an instantaneous feeling of comfort with the patient. The nurse becomes increasingly able to remove the self intellectually from the countertransferential feelings, assess the source of the transference within the patient, and is thus able to process the symbolic meaning of the patient's behaviour and actions. This enables the nurse to stop the self from reacting to the patient in a way which mirrors the reactions of everyone else in the patient's social surround.

In situations of negative countertransference, an awareness of countertransference enables the nurse to police the self's body language, tone of voice, and processing remarks in order to not transmit negative countertransference to the patient. The nurse is well aware when an attempt to police the self's responses has not been successful. At times, the nurse is aware that the patient has sensed the presence of negative countertransference because the patient has stopped the interaction by verbally withholding or the patient avoids further interactions with the nurse. However, the self is also increasingly able to judge how to reframe feelings of frustration into appropriate comments which serve to identify the effects of the patient's behaviour on the process of the interaction. The self experiences a sense of mastery when countertransference feelings are controlled and a positive patient outcome is achieved. Conversely, the nurse is increasingly aware of situations in which the self's inability to recognize and effectively deal with the countertransference has put both the self and the patient at risk.

There is a growing awareness that situations, in which the nurturing, concrete, care giving role of the nurse is validated by the patient, are less likely to provoke countertransference. In situations where the patient has a chronic mental illness, countertransference is less likely to be evoked because of the differences in the situational factors of the nurse and the patient. These self-perceived differences preclude strong feelings of identification with the patient and thus, strong countertransference feelings are less likely to occur than in situations where strong feelings of identification with the patient are present. Conversely, negative countertransference can be evoked by the frequent readmission of patients who have chronic mental illnesses because of the seeming inability of the nurse to aid these patients in overcoming the effects of their illnesses and adapting to community life. Thus, these patients fail to validate the care giving role of the nurse by remaining ill.

Feelings of overprotectiveness for the patient signal positive countertransference. An increasing sense of mastery in the nurse allows the incorporation of observations by peers that the nurse is assuming too much responsibility for the patient's welfare and the self is increasingly able to draw back and provide less quantitative, but more appropriate care.

Self-awareness facilitates the ability of the nurse to recognize the presence of countertransference in colleagues. The countertransference of colleagues is interpreted as stemming from several possible roots. Colleagues may be at a less advanced level of self-awareness, and therefore more susceptible to the effects of countertransference. There may be discomfort with the aroused feelings which precludes an understanding of countertransference as an important therapeutic tool. However, the increasing sense of self-mastery enables the nurse to provide guidance and support to colleagues in an affirmative manner which allays some of the confusion experienced by colleagues. The nurse is able to draw from the self's own past experience of confusion. The nurse's ability to step back from the affect generated in response to the situation, and subsequently process the dynamics of the situation for others, enhances everyone's understanding of the situation in particular, and of countertransference in general.

Differing role requirements which are predicated by the nurse's encounters with different situations, and which often require rapid shifts in style, can be difficult for the self to accommodate. The self struggles to provide the right attitude at the right time in the right situation but experiences a sense of resentment at not being able to be fully attentive to the patient and to the self in each situation.

Positive support from colleagues enhances the ability of the nurse to understand the limitations which must be placed on the provision of care in order that a corrective experience is proffered to the patient. The provision of positive support to the nurse, and at times the team, creates an atmosphere in which the self is freed to generate approaches which may not have been previously considered. Conversely, negative support may cause the nurse to isolate the self from the team because of the resentment engendered. The self perceives that one is expected to deal with unacceptable feelings about the patient without help.

The continuing struggle within the self to acknowledge and understand countertransference is exemplified by the struggle to accept the remarks of others, whether they occur informally in passing or whether they are part of formal supervision. In situations where negative support is indirect and takes the form of negative remarks about the patient, the nurse may assume the judgment of others by a process of guilt by association. This is, in part, engendered by the self's own feelings of inadequacy about one's seeming inability to help the patient progress. The nurse experiences regret that a more direct form of questioning did not occur as this may have served to enhance the ability of the self to understand how the negative countertransference was interfering with the relationship between the patient and the nurse.

Alternately, formal supervision is experienced as negative when it inhibits the nurse's sense of direction in what to explore with the patient. The nurse recognizes that without leadership, the self cannot progress beyond the limitations of the self in interactions with patients, and thus determines that the best course is to err on the side of safety for the patient in not exploring what is beyond the self-perceived ability of the nurse to process.

At times, the nurse outwardly appears to ignore negative remarks. However, the nurse may cognitively weigh the relative truth value of the remarks and self-question in relation to them. With a growing self-awareness, there occurs recognition that all remarks, whether they be direct or indirect, positive or negative, provide a touchstone for the self in bringing into consciousness that which may, as yet, be unconscious.

The nurse comes to realize that no matter how much supervision and support is offered, the self is alone with the self in interactions with patients. The comments and interpretations of others overlay the process of the interaction between the nurse and the patient in that they provide a viewpoint which must be evaluated against what is now being experienced. In addition, the nurse must process the self's emotional reactions to what the patient is saying and interpret the meaning embedded in the words. The management of this triad of forces requires an exquisite level of ability within the nurse.

The nurse who has a developed understanding about countertransference and who has incorporated this into practice, is aware of the need to oscillate the level of attachment between the self and the patient in order that the self may draw back when necessary, and draw in when it is called for. The nurse understands that a desire to self-disclose to the patient may or may not be driven by the self's unconscious needs. The self works to assess the appropriateness of the self-disclosure from the view of what the patient needs before making the decision. The nurse becomes more able to judge the difference between when countertransference is present and when the self is experiencing an ordinary reaction that anyone might have when faced with similar patient behaviour.

In situations where the negative countertransference is of such strength as to negate the possibility of self-monitoring, the nurse has the self-confidence to ask a colleague to assume care. In situations where self-monitoring alerts the nurse that the self is experiencing or has experienced issues similar to what the patient is experiencing, self-policing takes the form of attempting not to impose what the self needs onto the interaction. When the self recognizes that empathy is present, the self is able to skillfully guide the interaction in such a way that the patient need not spend so much time trying to make himself or herself understood, and thus, the therapeutic relationship is opened up.

In situations of positive countertransference, self-monitoring takes the form of knowing when the self is assuming too much responsibility for the patient, or recognizing when the self, because of strong feelings of identification with the patient's situation, has predetermined the course of the therapy in a way which precludes the patient's unique experience and wishes. The self also assesses what the patient is asking for and what it is reasonable to give, even if this is sometimes contrary to the wishes of the nurse. Alternately, the nurse may deliberately assume a great deal of responsibility for the patient, give more than is strictly necessary, and not experience regret because the result was a positive outcome for the patient.

The nurse comes to appreciate the complexity of countertransference and experiences lingering regret for past interactions which would have had a better outcome had the nurse been more aware of what the self and the patient brought to the interaction. However, there is a poignant recognition that the development of self-awareness had to unfold as it did, that self-awareness does not come without pain, and that the growth of self-awareness is an infinite process. To think anything else would be to acknowledge that one had not learned anything at all.

Appendix E

Bracketed Assumptions

The following are the investigator's assumptions and beliefs about the phenomenon of countertransference.

1. Countertransference is a normal reaction encountered daily in psychiatric/mental health settings.

2. Countertransference is an unconscious process which gradually comes into awareness, sometimes long after the provocative event.

3. Countertransference manifests itself in varying degrees and types of behaviour in the nurse, some of which are punitive to the patient.

4. A high degree of ego strength in the nurse as a result of having resolved some of his or her own issues contribute to a more therapeutic response to the patient when one is confronted with countertransferential feelings.

5. Nurses need to feel secure in discussing these self-perceived socially and professionally unacceptable feelings.

6. The social context of an hospital unit is a factor in limiting or encouraging the expression of countertransferential material.

7. A theoretical knowledge of psychodynamics is imperative to the nurse working in the psychiatric/mental health area.

8. Nurses understand and recognize the mechanism of projective identification which originates in the patient.